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Canada

RESTRICTIVE TRADE PRACTICES COMMISSION

HEARINGS RELATED TO THE MANUFACTURE, DISTRIBUTION
AND SALE OF DRUGS

HEARINGS

HELD AT

**MONTREAL
TORONTO**

VOLUME 13-16

OCTOBER 2, 16, 17 and 18, 1961

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Professor H.J. Fuller



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INQUIRY UNDER SECTION 42

OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale
of drugs

By Director of Investigation and Research
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C. -- Chairman

A.S. WHITELEY, M.A. Member of the
Commission

PIERRE CARIGNAN, Q.C. Member of the
Commission

F.N. MACLEOD
representing the Director of Investigation
and Research Combines Officer,

Proceedings of hearings commencing at
10.05 a.m., Monday, October 16th, 1961,
et seq in the City of Toronto, in the
Province of Ontario.



Montreal, Quebec,
October 2nd, 1961.

---On commencing at 10:00 a.m.

THE CHAIRMAN: We will bring the hearing to order, gentlemen. As most of you know -- probably all of you -- this is a hearing in Montreal, an inquiry into the drug industry, an inquiry begun by the Director of Investigation and Research under the Combines Investigation Act quite a long time ago, and the volume of material collected by him was presented to the Commission early this year.

Hearings have been held in various cities across Canada and we are now proposing to hold this hearing in Montreal and expect to conclude the hearings in Toronto beginning on the 16th of this month.

I would like to have, first of all, the names of those who are appearing this morning on behalf of themselves or of clients, and the people whom they represent.

Mr. McLeod, you are representing the Director, and there is nobody with you?

MR. McLEOD: No, sir.

MR. FRAWLEY: I am appearing for the Province of Alberta.

MR. HUME: Mr. Chairman, I am appearing for Canadian Pharmaceutical Manufacturers' Association.

MR. ANTORT: Mr. Chairman I am appearing on behalf of Nordic Biochemical Industries Limited.

MRS. SIMS: Mr. Chairman, I am appearing for the Canadian Association of Consumers.



1 THE CHAIRMAN: We have had so far presented
2 to us in advance of the hearing only two briefs, one
3 by the Canadian Association of Consumers and one by
4 Nordic Biochemicals Limited. We did, however, have
5 some information from others that they might perhaps
6 be presenting briefs or making representations orally
7 to us, and I thought we might just see if any of those
8 people are here in addition to those who have already
9 indicated their presence.

10 Is there anybody here for Public and Industrial
11 Relations Limited?

12 MR. McDONALD: Yes, Mr. Chairman.

13 THE CHAIRMAN: You won't be making any
14 representation?

15 MR. McDONALD: No.

16 THE CHAIRMAN: Dr. Moriarty: is he here by
17 any chance?

18 THE CHAIRMAN: Mr. Angers, will you be
19 presenting a brief?

20 MR. ANGERS: No, I am here on a watching brief.

21 THE CHAIRMAN: You are acting for a
22 pharmaceutical company: which one?

23 MR. ANGERS: No, I am not acting for anyone
24 at the present time.

25 THE CHAIRMAN: We had a letter from Mr. Paul Morand,
26 of L'Association des Pharmaciens de la Province de Quebec.
27 Is he here? I understood they would be presenting a
28 brief.

29 Is there anybody here from the National
30 Council of Women?



1 Then, we had a letter from the Association
2 of Pharmacists of the Province of Quebec: is there
3 anybody here representing the Association?

4 It looks as though we might not be too long
5 with the proceedings in Montreal, and I understand
6 that the Canadian Association of Consumers would desire
7 to present their brief first as their representatives
8 have other commitments for today. Mrs. Sims, would
9 you proceed?

10 SUBMISSION BY THE QUEBEC ENGLISH PROVINCIAL BRANCH
11 OF THE CANADIAN ASSOCIATION OF CONSUMERS

12 MRS. SIMS: Gentlemen: The Quebec English
13 Branch of the Canadian Association of Consumers is one
14 of the oldest and largest provincial branches in this
15 association. From it's very inception, through
16 resolutions and letters, it has received protests from
17 its members in relation to the high cost of our most
18 necessary drugs and the hardships these costs inflict,
19 in moments of serious illness, on our low-income groups.

20 These protests and evidence of anxiety have
21 greatly increased in number of late, with the appearance
22 of the ethical drugs, that are so often replacements
23 for impaired bodily functions, and hence must be used
24 over long periods of time and even in some cases for
25 life.

26 This constant testimony to consumer uneasiness,
27 in a field of vital importance to the nation's health and
28 to it's ability to meet the financial costs of illness,
29 makes us welcome your Commission's investigation into
30 the whole picture of our manufacture, distribution and



1 sale of drugs, and we appreciate the occasion you are
2 granting us of expressing our membership's long-standing
3 protests on the subject.

4 One of the firmest positions our Association
5 has taken...at all levels...throughout the years of
6 it's existence, has been it's insistence on the right
7 of consumers to buy in full knowledge as to the quality
8 and value of what they buy. However difficult this may
9 be to fully achieve in the complex field of our new
10 drugs, we hope nevertheless that the present investigations
11 may help us to achieve it, at least partially.
12 Ignorance is never a safe territory...even though it is
13 occasionally a profitable one. The blindfolded are
14 always suspicious...and usually resentful. Today the
15 fact that the costs of ethical drugs in Canada is higher
16 than almost anywhere else in the world, and the
17 suspicions and resentments this breeds, are we feel, as
18 damaging to the prestige of the Canadian Pharmaceutical
19 Industry as they are disquieting to consumers. Indeed
20 we are sometimes asked why the name "ethical" was given
21 our more modern drugs, when consumers believe...rightly
22 or wrongly...there there is so little that is ethical
23 about their prices.

24 I regret that our provincial association
25 does not feel competent to assess, in detail, the many
26 factors that go into the pricing of drugs. We are
27 convinced however, from the testimony of our members
28 and branches, that a number of our major, new drugs,
29 essential to the health and even survival of many,
30 are today priced far above the reach of a significant



1 number of our seriously ill and of our aged citizens.

2 In too many cases to be tolerable, elderly
3 people, whose sole income is their old-age pension,
4 must spend more than half that small pension on drugs
5 that are needed to keep themselves alive...to find
6 that what is left them is not sufficient to let them
7 live, unless charity intervenes. Because of the...
8 perhaps inevitable...high costs of life-perpetuating
9 drugs such as insulin and cortisone, rescue from a
10 tragic, physical condition that a sojourn in hospital
11 cannot cure, remains, for large sections of our
12 province, a perquisite merely of the well-to-do. A
13 situation that existed everywhere a few generations
14 back, but which is no longer tolerable to our modern,
15 social conscience.

16 We doubt if a study of pricing alone can cure
17 this situation, and though this may not be strictly
18 within the field of your inquiries, may we take advantage
19 of this occasion to state our belief that it represents
20 as much of a national problem as the high cost of
21 hospitalization, which is now concerning our federal
22 and provincial governments. Today the need for
23 special drugs...after leaving hospital...may last as
24 long and mean as much, to health and life, as
25 hospitalization itself and should form part of all
26 future government plans for the care of our low-income
27 sick.

28 In this relation...and in view of the visibly
29 increasing sense of responsibility for the health of
30 Canadians which our governments, at all levels, are now



1 showing...we wonder how logical, and justifiable, is
2 the additional weight which the 11 per cent federal tax
3 on drugs, excise duties in some cases and possibly
4 some of the hidden taxes, woven into our tax-structure,
5 of which we are not aware, now adds to the high cost
6 of being ill? Essential drugs...like food...should not,
7 we believe, be revenue-raising objectives. And we
8 wonder if even in corporation taxes there should not
9 be distinctions (as there is between the farmer as a
10 food-producer and the average citizen) between
11 essential and non-essential industries. Corporation
12 taxes appear in the price of all that we buy, but
13 should they appear with an equal weight in the cost
14 of products that can affect health and survival?

15 In short we question whether, ethically, the
16 finger of government has any place on the scales by
17 which are weighed the costs of our vital drugs?

18 We are being told that costs of putting
19 up prescriptions may soon have to be increased, due
20 to the additional form-filling and purchasing
21 technicalities burdens of work being thrown on
22 pharmacists through the new and stringent regulations
23 against the barbiturate or goof-ball menace just
24 enacted and in vigor since September 15th. This makes
25 all the more urgent the need to remove from prescription
26 prices those factors that governments have introduced.

27 ON TODAY'S JUSTIFICATIONS FOR DRUG-PRICES

28 The Canadian Association of Consumers has
29 never been just a narrow "Consumer-First" Association.
30 Our Quebec English Branch realizes that a margin of



1 profits sufficient to cover the costs of our
2 pharmaceutical industry's vast and valuable research
3 programs, forms an important...and, to a point,
4 justifiable part of our present high cost of illness.

5 We are also willing to accept the statement
6 of many retail pharmaceutical stores that today...
7 after their expert pharmacists salaries are deducted from
8 gross profits...the prescription side of their business
9 shows only a marginal profit.

10 We recognize that consumers must...in their
11 own interests...accept the need of salaries high
12 enough to render the five years of expensive
13 training a pharmacist must undergo fully rewarding, if
14 we wish to keep on having enough competent pharmacists
15 for our ever-growing needs.

16 And we see no benefits for consumers in
17 reducing unreasonably the profits that are the incentives
18 that give us a pharmaceutical industry.

19 But here our consumer-charity ends.

20 Just as doctors are recognized as having moral
21 obligations towards public welfare greater than their
22 personal profit-and-loss interest, so does the
23 pharmaceutical industry, that has elected to deal with
24 products that affect health and life, possess, as we
25 see it, obligations that should impose certain
26 disciplines on it's profit and merchandising and pricing
27 practices. We feel that in many fields of public
28 service...as in the scholarships bestowed, integrity
29 of research and search for knowledge....~~this industry~~
30 admirably recognizes it's obligations, but where it's



1 most direct contact with the public...via prices and
2 some merchandising practices...are concerned, we are
3 not so sure that it does.

4 The research carried on by our leading drug
5 manufacturing firms has proven most valuable to
6 society; but we do not believe that this research has
7 been altruistic...nor feel that it should be. Though
8 values produced in the name of an industry's self-
9 interests are still values, we see no justification
10 for the consumer to be called upon to pay, through
11 the medium of prices, the total cost of the competitive
12 research carried on, in an industry's own interest and
13 as a long range investment.

14 Again - if the prescription counter of a
15 retail pharmacy today shows only a small margin of
16 net profit, as we have been told, may it not be
17 because the proprietor has neglected to include in his
18 bookkeeping the public relations and prestige values
19 of this side of his business, without which he would be
20 running merely a second-class, variety store, and the
21 fact that it is the side of his business where tacit
22 price-maintenance agreements throughout the trade can
23 operate most easily to eliminate price-competition?

24 We have some reason to believe that this
25 evasion of price-competition between retail
26 pharmaceutical outlets, through a widespread
27 readiness to accept "suggested" retail prices from
28 manufacturers...a system originally called resale
29 price maintenance...is still, today, a significant
30 factor, at retail levels, in the high costs of our drugs.



1 A few years back our national association
2 challenged, and obtained some restrictions, in relation
3 to the right then claimed by a number of industries,
4 including the pharmaceutical industry, to impose, from
5 the manufacturing level, the resale price of products
6 they had sold...been paid for...and hence no longer
7 owned.

8 The restrictions obtained simply prohibited
9 however the exercise of the resale price maintenance
10 private system of law and punishment against retailers
11 refusing to accept a drug firm's right to set his
12 retail prices for him. It did not prevent voluntary
13 agreements on prices...reaching across a province
14 and often across a nation...between pharmacists and
15 pharmaceutical manufacturers, that froze prices at one
16 level without reference to the individual outlets
17 variations in costs of doing business.

18 Today, it is generally recognized, we believe,
19 that this system of resale price maintenance - though
20 deprived of it's teeth - is still widely practiced
21 in most of the fields that originally found it
22 rewarding, and thus limits to a degree the protection
23 of general price-competition that the ban on the
24 "coercion aspect" of the practice sought to give to
25 consumers.

26 Our Quebec Branch would be interested,
27 gentlemen, in any study or investigation this
28 Commission could make concerning the role played in
29 today's ethical drug prices by this still widespread
30 (we believe) elimination of price competition in the



1 retail, pharmaceutical field. And we wonder whether
2 this practice...(which defeats the intention to protect
3 consumers, that was, we believe, the purpose of the
4 previous legislation on resale price maintenance.)
5 ...should be allowed to continue?

6 It is true that variations in prices in
7 an occasional pharmacy is evidence that some drugstores
8 use their present freedom to set their own retail prices,
9 and we welcome the fact. But we question whether a
10 system in restraint of trade, like resale price
11 maintenance, is any less objectionable...in the areas
12 where we believe it is still widely used...or less
13 prejudicial to public interest, when exercised
14 voluntarily, than when it is carried out under
15 coercion?

16 LACK OF PUBLIC INFORMATION

17 Our Branch in Quebec regrets the lack of
18 information, easily accessible to the general public,
19 through which consumers could learn -

20 (A) The appreciable savings obtainable, in
21 many cases, by the purchase of a drug
22 through it's generic, as against it's
23 brand or copyright name,
24 and

25 (B) Of the equal inspection both generic and
26 trademarked or brand name drugs receive
27 from our Pure Food & Drug Department at
28 Ottawa.

29 Today the average consumer is often afraid
30 to buy non brand name types of medicine, partly because



1 of the psychological effect of vast advertising programs
2 and partly because they have been frequently told that
3 these are inferior in quality and/or unsafe. We hope
4 some of this inadequate information will disappear
5 following the Report of the Findings of this
6 Commission. We would like to see a simple,
7 informative pamphlet, put out perhaps by the Pure Food
8 & Drug Department, outlining the protection this over-
9 worked and admirably devoted government department
10 gives to the buying public, and providing a list
11 of the more habitually used generic drug names. Even
12 in such everyday products as petroleum...as against
13 vaseline...there is a saving in price which is not too
14 easy for consumers to learn.

15 Many doctors, happily, do give such information
16 to their patients. But many more seem too busy to think
17 of these latter in terms of medical costs, in addition
18 to terms of their medical needs, or to adjust
19 prescription, as far as possible, to the purses of
20 these patients. A pharmacist can only fill a
21 prescription as it is written, and we would like to see
22 the medical profession take a wider responsibility than
23 it now does in assisting consumers to buy the least
24 costly, safe products for their needs.

25 We would like also here - in the name of the
26 membership of our provincial branch - to express our own
27 appreciation of the work of the Pure Food and Drug
28 Directorate and it's value to consumers. Like many
29 of our members, we are somewhat shocked at the
30 discrepancy existing between the operative budget of



1 so vitally important a government agency (as judged by
2 the size of it's staff) and that of other government
3 departments far less vital to the public interest.

4 ON THE PATENT ACT IN RELATION TO DRUGS

5 Our Quebec Consumer Association is confused
6 by the conflicts between statements that our patent
7 laws, unlike those in the United States, makes
8 monopolies through patents impossible here, made to
9 us by various officials in the pharmaceutical industry,
10 and the evidence in the material submitted to your
11 Commission, that the provisions to prevent monopolies
12 in the Patent Act, and specifically the compulsory
13 licensing system, have failed to prevent monopolistic
14 control by manufacturers over drugs they have patented.
15 Our inquiries have led us to believe however that
16 this situation may be largely due to the small number
17 of drug firms in Canada able to compete, via
18 compulsory licences, with our established giants in
19 the industry, and to the difficulty, for even our
20 strongest firms, of competing against the mass-production
21 powers of the U.S. firms who hold Canadian patents and
22 control many items on our drug market.

23 Irrespective of the cause, the results
24 nevertheless seem to be the creation of a monopoly
25 for our Canadian firms that human nature may find
26 hard to resist using for profit-increasing purposes...
27 and the importing across Canada's borders of the
28 dangerous price monopoly conditions existing in the
29 United States. We urge this Commission to suggest
30 a searching re-examination of the whole patents and



1 trademark and copyright situation.

2 We would like to urge moreover an
3 examination of the effect on consumer interests of
4 trademarks granted for periods long enough to turn a
5 brand name into a symbol of the ingredient in the
6 buying public's eyes, thus making the article's
7 protection against future similar products almost
8 a perpetual one. Many cases exist where such a trade
9 name has become a generic name for a product and
10 has effectively entered the consumers language....so
11 creating an unending monopoly, with all it's possible
12 abuses. Trademark or brand name protection that
13 covers close to the span of one generation seems
14 to us open to question.

15 Old age and illness...whether chronic or
16 acute...is the most defenceless area in the life of our
17 people. In this area drugs and drug supplements for
18 functional failures must, today, too often be bought
19 under conditions similar to those created by a gun held
20 at one's head. Any field in which one must buy in
21 haste, fear and urgent need requires public trust to
22 a far greater degree than any other field...and trust
23 and prices are closely related. The partnership
24 between the pharmaceutical industry and the consumer
25 is too vital to be shaken...as it now is..by suspicions
26 of exploitation, or unfair resentments, and we hope
27 your findings, gentlemen, may help us assess what we
28 must gracefully accept...and what we can legitimately
29 insist on having corrected in today's frightening costs
30 of being ill.



1 THE CHAIRMAN: Mrs. Sims, would you like to
2 add anything to the brief, or to make any comment on
3 any of the points that were discussed in the brief?

4 MRS. SIMS: No, of course, it is very general.
5 Mrs. Vautelet has been doing some research in Montreal.
6 I live in Lennoxville, and have been doing research
7 in the Lennoxville, Sherbrooke area, and since this
8 was written I was very interested in the subject, and
9 I have called on many pharmacists, and I have spoken
10 to quite a few consumers who I knew had to use quite
11 a few drugs, and I have spoken to several doctors.

12 In our situation out there, as far as
13 getting prescriptions filled is concerned, the
14 pharmacists tell me that using the generic names
15 may cause confusion. I speak to the doctors, and they
16 say that is ridiculous. You see, I am only a lay
17 person, and I am not sure of who is right in some
18 of these cases, but a great many of the doctors out
19 there are starting to use the generic name, and I,
20 on speaking to consumers, and with pharmacists all
21 along the same main street in Sherbrooke, and they
22 were told to shop around, and the price varied in the
23 prescriptions from \$5.50, it came down to \$3.00, the
24 same prescription, and there was several cases of
25 that, I might say.

26 And then there is another thing, I haven't
27 see them, but perhaps you gentlemen have, but that
28 was some of the doctors spoke of, of course it is their
29 own Canadian Medical Journal, which as I understand
30 prints, after it is passed by their Medical Board for



1 the magazine, any new drugs that come. They give their
2 write-up on them, and what they contain, what they
3 can do, what they find out from the manufacturers and
4 so on and so forth. But then there are quite a
5 few other magazines which these doctors claim are
6 coming in to their offices very regularly, which are
7 well, they are not as reliable, and it is more
8 advertising, just as your products on TV are, not
9 for your drugs, but for your medicine, and that that
10 confuses the issue. Quite a few of the doctors who
11 don't take the time to sit down, which they should
12 as all these doctors said, and read their Medical
13 Journal, and learn about these new drugs, and learn
14 the generic names, so that they can use them and
15 thereby give the consumer the chance to shop around
16 at different pharmacies.

17 THE CHAIRMAN: When you refer to the price
18 for the same prescription changing from \$5.50 to
19 \$3.00, just to be quite sure, would that be a drug
20 sold under its generic name by the manufacturer, or
21 would it be the same drug under the trade name, but
22 sold at a lower price because the prescription was
23 given by generic name?

24 MRS. SIMS: No, I don't know that. The
25 prescription was given by the doctor. In fact there
26 were three different instances of almost the same
27 variation, and I cannot tell you what the drug was,
28 but it was given by generic name, and the doctors
29 who had given these had said to the patient: "Now,
30 you don't need to just go to one drugstore. There may



1 be a variation in price".

2 THE CHAIRMAN: But you don't know whether it
3 was a drug that had a trade name, or was sold simply
4 under the generic name?

5 MRS. SIMS: No I don't know. It was generic,
6 I am told.

7 MADAME VAUTELET: I did some of the research
8 for this, and different pharmacies have told me that
9 the difference between the generic and trademark
10 names generally they say are better or purer, generally
11 run as high as 50 per cent between the trademark,
12 such as samples for aspirins and acetylsalicylic acid, I
13 cannot pronounce it properly.

14 THE CHAIRMAN: ASA is easier. Aspirin, of
15 course, is not a trademark drug, but it is a trade name.

16 MADAME VAUTELET: Yes.

17 THE CHAIRMAN: Mrs. Sims, you refer to prices
18 and some merchandising practices. In the phrase, "Some
19 merchandising practices", were you referring only to
20 resale price maintenance and to the non-use of the
21 compulsory provisions of the Patent Act. I think those
22 were the only things actually spelled out in the brief?

23 MRS. SIMS: That is correct.

24 THE CHAIRMAN: You had nothing else in mind?

25 MRS. SIMS: No .

26 THE CHAIRMAN: With regard to resale price
27 maintenance, I might point out that agreements on
28 prices are contrary to the Act, just as much as a
29 compulsory requirement that a retailer shall sell only
30 at, or not below certain prices. If agreements are made



1 to set the level of prices horizontally, that is also
2 contrary to the Combines Investigation Act. If prices
3 arrive at a level without there being any agreement,
4 and without there being any persuasion, shall we say,
5 that can be discovered at any rate. If you have
6 evidence of voluntary agreements on prices, the
7 Director might be interested in hearing about it.
8 But that is not really part of our inquiry to any
9 extent on this occasion, because there have been no
10 allegations of resale price maintenance made by the
11 Director. But if there is evidence of retail price
12 maintenance, I am sure the Director might be glad to
13 hear it. You might follow it up.

14 MADAME VAUTELET: On this point consumers
15 are confused. They find in a whole range of
16 pharmacies exactly the same price for the same
17 articles which seem to have been arrived at simultaneously.
18 They have been told by, sometimes pharmacists who
19 don't have the same prices, that there are price
20 lists issued by manufacturers, giving suggested resale
21 prices. Now, would that not be evidence of an
22 agreement?

23 THE CHAIRMAN: Not necessarily, Madam
24 Vautelet.

25 MADAME VAUTELET: Well, it would be suspicion.

26 THE CHAIRMAN: There could be an agreement
27 that they could use the prices in the list, but they
28 might not ---

29 MADAME VAUTELET: If in a certain area half
30 a dozen pharmacists use the prices according to the



1 list, would that in a court of law indicate ---

2 THE CHAIRMAN: It might be difficult to prove
3 that it was anything else.

4 MADAME VAUTELET: That was the consumers'
5 wonder.

6 THE CHAIRMAN: Because people can arrive,
7 they may think that suggested prices are about right
8 and use them as a matter of course. The question is
9 whether it does amount to anything in the nature of
10 an agreement.

11 MADAME VAUTELET: What kind of evidence would
12 this Commission require a consumer, for example, how
13 could one prove anything more than by price list and
14 the simultaneous adoption of it?

15 THE CHAIRMAN: There have been ways by which
16 the Director has found evidence which indicates more
17 than a mere following of suggested prices in other
18 industries, cases where meetings have discussed the
19 matter, and sometimes motions have been passed and
20 recorded which indicate that people are expected to
21 follow the list prices, and they will be checked up
22 if they don't. That sort of thing.

23 MRS. SIMS: As a consumer just going around
24 and having had these complaints come to me over the
25 years, I am vitally interested, and when I went around
26 as just an ordinary person, not knowing very much
27 about it, and talked to these pharmacists, one question
28 I asked them directly was: "Do you get any set list
29 ~~of prices that you~~ are supposed to follow?" I asked
30 that question. I never got a yes, and I never got a



1 no. They always switched the subject. To an ordinary
2 person going in, that immediately makes me think you
3 are avoiding that because they answer other questions well
4 and helpfully, but not one would answer that direct
5 question yes or no.

6 THE CHAIRMAN: Of course, the absence of an
7 answer does not constitute evidence.

8 MRS. SIMS: No, I know, not legally, but to
9 a lay person asking questions.

10 THE CHAIRMAN: If you have read, and I presume
11 you have, the Director's volume of material, there are
12 some cases of list prices being circulated.

13 MRS. SIMS: I gathered from them, sir, that
14 it was, at least, I asked them whether they got them
15 from the Pharmaceutical Association, and that is what
16 they would not answer.

17 THE CHAIRMAN: Is it the correct word, on
18 page 6. You are speaking of petroleum as against
19 vaseline. Petroleum is a good many other things
20 besides vaseline?

21 MRS. SIMS: That is what the pharmacists use.

22 THE CHAIRMAN: Petroleum jelly maybe.
23 Petroleum is such a wide generic name. It could cover
24 many other things.

25 MADAME VAUTELET: It should be petrolatum,
26 I think.

27

28

29

30



1 THE CHAIRMAN: Do any of the other representatives
2 have questions?

3 MR. HUME: If I may direct one or two
4 questions, Mrs. Sims, so I can understand this brief
5 which I have seen for the first time this morning.
6 May I congratulate you on your brief first, Mrs. Sims.
7 You are a member of the Quebec branch of the same
8 association that Mrs. Plumtree was in Ottawa?

9 MRS. SIMS: That is correct, sir.

10 MR. HUME: You are the Quebec branch. What
11 was Mrs. Plumtree? Was she the National Association?

12 MRS. SIMS: That is right, sir.

13 MR. HUME: It is made up of various provincial
14 branches.

15 MRS. SIMS: Yes, representatives elected
representatives.

16 THE CHAIRMAN: This is the Quebec English
17 Association?

18 MR. HUME: Mrs. Sims, would you turn to page
19 7 of your brief. I just don't understand the
20 reference that you made in the third paragraph where
21 you speak about trademark or brand name protection that
22 covers close to the span of one generation. I wonder,
23 Mrs. Sims, if you are under the misapprehension a
24 trademark lasts only as long as a patent, seventeen
25 years. Was this what was in your mind? I think I
26 should tell you it is my understanding of trademark
27 that they last indefinitely and it isn't just a span
28 of one generation. A trademark will last indefinitely
29 as long as it is renewed every twenty years.

30 MRS. SIMS: We understood it did last longer



1 than seventeen years, but we feel it should not.

2 MR. HUME: You refer to the fact as
3 something you think should not come about, the
4 trademark protection, you say that covers close to the
5 span of one generation. I thought you were speaking
6 in terms of the seventeen years.

7 MRS. SIMS: Twenty-five years we were thinking
8 of.

9 MR. HUME: Mrs. Sims, I wonder if you would
10 be good enough to turn to page 4. I have only just seen
11 this this morning. You will have to bear with me.
12 You refer to the research of drug manufacturing firms
13 and you indicate that you don't believe this research
14 has been altruistic, nor do you feel it should be.
15 You seem to make the point that you don't think the
16 cost of this research should be reflected in the price,
17 that somebody else should contribute to the cost.
18 I wonder what you mean?

19 MRS. SIMS: It shouldn't. We feel it
20 shouldn't. The cost of the drugs is so high we
21 feel that the consumer must be paying the cost of the
22 research. Research is very valuable and benefits
23 the consumer and everyone in the long run but a great
24 deal has been said that the -- it has been said that
25 sometimes the drug companies have to do so much research
26 that that is a costly part of their program and the
27 consumer is willing to pay part of that, but after all
28 every industry, if they are going to stay in business,
29 has to do research, have to have a research program.

30 MR. HUME: If the consumer doesn't pay



1 For the cost of research in industry who do you envisage
2 would pay, government grants?

3 MRS. SIMS: Well, I think the industry itself
4 should bear some of the cost of that. The total cost
5 should not be paid by the consumer.

6 MR. HUME: Industry only receives revenue
7 from the sale of its products. I was wondering where
8 you think the industry is going to get funds to pay
9 for research if it isn't from the sale of these
10 products?

11 MRS. SIMS: I think the stockholders.

12 MR. HUME: Your idea is that the dividends
13 should be reduced, if any, to pay it. Have you any
14 evidence that is not already being done or have you
15 made any investigation with respect to that?

16 MRS. SIMS: No, the only reason the consumer
17 has the impression that he or she is paying the full
18 cost of the research is because that part of it has
19 been stressed such a great deal by the manufacturers,
20 that that is the heavy cost side of their business,
21 shall we say.

22 MR. HUME: That may be. The only thing
23 I am having a little difficulty in following your
24 reasoning in your brief is that if the manufacturer
25 whose only revenue comes from the sale of its products
26 is going to spend money on research, you are not
27 therefore suggesting there should be some federal
28 grants from somewhere else? It has got to come
29 out of the price of the product.

30 MRS. SIMS: Not totally.



1 MR. HUME: Where is this going to come from?

2 MRS. SIMS: The point is that if it is,
3 as in my findings that I spoke about, the difference
4 in the cost of drugs between \$5.50 and \$3.00 for the
5 same prescription that the drugs are therefore costing
6 too much. Aren't they?

7 MR. HUME: I don't know.

8 MRS. SIMS: I mean some people are.

9 MR. HUME: I am not the one to ask that
10 as I act for the Manufacturers, Mrs. Sims, but I am
11 just sorry, and it may be my fault, but I don't
12 understand this point in the brief when you say that
13 the consumer should not be paying the cost of research
14 which is one of the costs of staying in business. I
15 am trying to find out where the money should come from
16 if it isn't coming from the sales. You and I, as
17 consumers, Mrs. Sims, we are paying the money that
18 goes into the company when we are buying a drug or a
19 can of peas. We pay the money that goes into the
20 company's treasury and part of that money is allocated
21 for research. I am trying to find out whether you mean
22 the research programs should be subsidized by
23 government agencies.

24 MRS. SIMS: Well now, I think that the
25 consumer feels that she must be paying, because of the
26 high cost of drugs, for the total research program
27 and that the industry, the manufacturing industry
28 is benefitting and, so is the consumer in the long run
29 as new drugs keep coming out. I feel that part of
30 the research program which, evidently, is a very



1 costly one should be borne by the companies.

2 MR. HUME: The company pays for it.

3 MRS. SIMS: Yes, that is right. They pay.

4 MR. HUME: That is my point.

5 MRS. SIMS: They must put the cost of the
6 research program into the drugs. We don't feel that
7 the total cost of the research program should be paid
8 by the consumer.

9 MR. HUME: Now then, be good enough to turn
10 to the bottom of page 5. I just don't understand
11 your reference on the lack of public information in
12 sub-paragraph (A). You say our branch in
13 Quebec regrets the lack of information easily
14 accessible to the general public through which consumers
15 could learn the appreciable savings obtainable in
16 many cases by the purchase of a drug through its
17 generic, as against its brand or copyright name.
18 It seems to me if it is easily accessible to the
19 general public why doesn't the Quebec branch know about
20 it?

21 MRS. SIMS: It isn't easily accessible -
22 regrets the lack of information easily accessible to
23 the general public. Maybe another word should be
24 in there.

25 MR. HUME: I misunderstood the English. It
26 is my fault. Then, in paragraph (B) you underline
27 the word equal, "Of the equal inspection both generic
28 and trademarked or brand name drugs..." Some
29 generic names have brand names to identify them on
30 the bottle. The inspection, as I understand it is of



1 | pharmaceutical products. I wonder if you could
2 | explain what you mean by paragraph (B).

3 | MRS. SIMS: I believe there are Food and
4 | Drug departments which inspect all the drugs which
5 | come into the country no matter where they come from
6 | under generic or trade or brand names, but the trouble
7 | is the consumer know this and you often feel in order
8 | to be sure that you have to take the brand name and
9 | the generic name to the consumer is often not known.

10 | MR. HUME: Have you had a chance of reading
11 | the evidence of Dr. Morrell in Ottawa?

12 | MRS. SIMS: Some of it, yes.

13 | MR. HUME: You will recall if you read his
14 | evidence the Food and Drug Directorate is unable to
15 | inspect all the drugs that come into that country,
16 | they make spot checks.

17 | MRS. SIMS: I realize that.

18 | MR. HUME: That is the kind of thing....

19 | MRS. SIMS: Just a moment, Mrs. Vautelet
20 | would like to say something.

21 | MADAME VAUTELET: May I say in questioning
22 | a number of pharmacists, retail pharmacists, the
23 | impression was given to quite a few of our members
24 | and to myself that the generic drugs weren't safe.
25 | This was never stated in so many words, weren't safe,
26 | with the implication they didn't get the inspection
27 | that the brand names get. A lot of consumers have
28 | the impression the Pure Food and Drug Department only
29 | inspects brand names. This, of course, is totally
30 | erroneous and the need to have the public informed of



1 this matter is quite urgent.

2 MR. HUMÉ: I see your point. In the next
3 paragraph, Mrs. Sims, you talk about the consumer
4 buying the non-brand type of medicine. I presume you
5 are talking of propriety or patent medicines and
6 not ethical pharmaceuticals. I mean with an
7 ethical pharmaceutical the doctor writes the
8 prescription and the consumer really doesn't choose
9 the product. I think your Mrs. Plumtree made this
10 point in Ottawa.

11 MRS. SIMS: That is correct.

12 MR. HUMÉ: You must be thinking there of
13 the propriety type of medicine.

14 MRS. SIMS: Yes.

15 MR. HUMÉ: Finally on page 6 in the third
16 paragraph you make reference to the medical profession
17 that I don't quite understand. You say "Many doctors,
18 happily, do give such information to their patients
19 but many more seem too busy to think of these latter
20 in terms of medical costs, in addition to terms of their
21 medical needs." I wonder what you mean by that. The
22 doctor makes the decision, presumably, with the
23 welfare of his patient in mind. He will prescribe a
24 certain pharmaceutical product. Are you suggesting he
25 has not discharging that duty?

26 MR. SIMS: No, no, the thing we are saying
27 and the doctors are interviewed -- I was up at a
28 hospital and I found that some doctors, they are pretty
29 busy people and don't keep up with the generic names,
30 the generic names of some of these drugs are often



1 | long and unpronounceable and they use the brand name
2 | in preference. Now, a great many don't, but what we
3 | mean is just like this doctor that I referred to before
4 | who gave his patient a prescription and he said,
5 | Now, that is the generic name. You take it down and
6 | see if there is any difference in the price. There
7 | being about three different drugstores within a few
8 | hundred yards of our main street in Sherbrooke. That
9 | is what I am referring to. Many doctors do that, say
10 | I will take the trouble to give the generic name, it
11 | will suit this person just as well and it will save
12 | him money.

13 | MR. HUME: Your point is the medical profession
14 | might, if they listen to you, might spend a little more
15 | time investigating generic and writing prescriptions
16 | in that way.

17 | MRS. SIMS: Yes.

18 | MR. HUME: I presume some are doing that now.

19 | MRS. SIMS: I think more and more are doing
20 | that.

21 | MR. HUME: A lot write prescriptions under
22 | the brand name because they have confidence in that
23 | particular manufacturer's products.

24 | MRS. SIMS: Yes.

25 | MADAME VAUTELET: Or are lazy.

26 | MRS. SIMS: Or are lazy, but I mean the thing
27 | is that in the generic, as these doctors explained to
28 | me you can bring the generic name of all the new drugs
29 | plus the brand names and the different varieties and
30 | they are -- you know, that gives you the contents. I



1 am trying to think of the correct word I want, but I
2 can't. It tells you exactly what is in there.

3 MR. HUME: Mrs. Sims, I suggest that you as
4 a housewife when you go to the grocery store and
5 buy a can of soup you buy a particular brand, Aylmer's
6 or Heinz, somebody you know, and you don't buy any
7 can of soup that you don't know who made it.

8 MRS. SIMS: Yes, but I would certainly do it
9 in relation to price.

10 MR. HUME: Of course. Thank you, Mrs. Sims.

11 THE CHAIRMAN: Mr. Frawley?

12 MR. FRAWLEY: I would like to associate myself
13 with my friend's remarks to you in complimenting you
14 on the brief that you have presented. It is a very
15 good brief. I was particularly struck with the
16 professional language that was used in describing the
17 situation in parts.

18 Now, Mrs. Sims, there are many aspects of
19 this question, but I would like to go fully into one
20 with you. You are aware, of course, that government
21 departments and large hospitals buy large quantities
22 of drugs, ethical drugs? Have you any idea as to the
23 price which those departments of government pay for
24 these ethical drugs?

25 MRS. SIMS: I know some friends of mine who
26 have got prescriptions filled in large quantity when
27 it was something they had to take over a long period
28 of time in the hospital before they left, and then
29 when they finally ran out and had to go to a drugstore
30 that they paid a great deal more.



1 MR. FRAWLEY: Yes, just precisely that. I
2 would like to discuss that with you for a moment. In
3 the hospital where the prescription is filled out of
4 the hospital pharmacy the patient pays something, but
5 pays a great deal less than what they have to pay
6 for the program of drug therapy after they are
7 discharged from the hospital. That is what you found
8 to be the situation?

9 MRS. SIMS: Right. They cost enough, sir,
10 even from the hospital.

11 MR. FRAWLEY: Would you be surprised to know --
12 you have never studied, I suppose, the price difference
13 in some of these drug quantities. Would you be
14 surprised to know in the Province of Alberta the
15 Minister of Health pays two cents for a tablet of
16 penicillin G sold to him by the British Drug House.
17 The retail price for the same tablet is 20 cents.
18 Did you have any idea that there was that sort of
19 difference?

20 MRS. SIMS: I had an idea, yes, but not that
21 much.

22 MR. FRAWLEY: That, of course, has no relation
23 to the cost. The cost is not known to me. My friend,
24 Mr. Hume, may open the book in Toronto on the 16th of
25 October. In looking at the prices at which they are
26 sold, not the cost, would you also be surprised to
27 know in another instance in the Province that the
28 Alberta Department of Health is paying for the supply
29 of Hoechst tolbutamide, which probably is Hoechst
30 orinase --. They pay four cents a tablet and it retails



1 | at fourteen cents. That, I suppose, does not
2 | particularly surprise you.

3 | MRS. SIMS: Do the prices not vary from
4 | province to province? Don't they?

5 | MR. FRAWLEY: I am pretty busy keeping up
6 | with what they do in Alberta. I don't know about the
7 | other provinces. I don't think we are the only
8 | province in Canada that have a drug program, have a
9 | drug program supplying drugs free to old age pensioners
10 | and people who are otherwise without means. I don't know
11 | if they have to pass a means test or not. I am
12 | speaking of that kind of thing. To go further I want
13 | to call to your attention in connection with these
14 | prices paid by government departments that there is
15 | competition. Do you know there is competition between
16 | drug manufacturers who do that supplying to the
17 | government departments?

18 | MRS. SIMS: I would certainly think there
19 | would be. I would hope so.

20 | MR. FRAWLEY: You wouldn't be surprised to
21 | know for the 1961 supply of penicillin G quotes were
22 | received in 1961 from the British Drug House from
23 | Ayerst, from Glaco, from Horner's, from Frosst, from
24 | Wyett, from Squibb and from the Alberta National,
25 | which is a wholesaler. Do you know of any similar
26 | competition in supplying to retailers in ordinary
27 | merchandising? Do you know of any similar
28 | competition on the part of the drug manufacturers to
29 | underbid each other to get those drugs onto the shelf
30 | of the retailer?



1 MRS. SIMS: No, I have no information on
2 that.

3 MR. FRAWLEY: Wouldn't you be surprised if you
4 were told there was no competition?

5 MRS. SIMS: No.

6 MR. FRAWLEY: Perhaps there are. I put it
7 to you that there is no competition at all when it
8 comes to supplying the retailer compared to the
9 competition of the drug manufacturers to supply
10 government departments or supplying hospitals?

11 THE CHAIRMAN: I think that Mrs. Sims said
12 she had no knowledge.

13 MR. FRAWLEY: What is that?

14 THE CHAIRMAN: I think Mrs. Sims said she
15 has no knowledge on that.

16 MR. FRAWLEY: Mr. Hume put it to you that the
17 cost of research, it would come from the sale of the
18 drugs, the money which the manufacturers get in from
19 the sale of the drugs. In putting it to you, I
20 ask you the question whether you would think there is
21 very much contribution by the Alberta Department of
22 Health to any research which the British Drug House
23 may wish to do in selling penicillin G at two cents.

24 MRS. SIMS: I don't know anything about that.

25 MR. FRAWLEY: I put it to you, if anybody
26 is paying for the research it is the patient who goes
27 in with the prescriptions and pays 20 cents for the
28 tablet.

29 MRS. SIMS: That is right, the public, the
30 consumer.



1 MR. FRAWLEY: And, therefore, I put it to
2 you that there is an apparent subsidizing of the cheap
3 prices which the governments pay by the high prices
4 which the consumers pay?

5 MRS. SIMS: Yes. Well, that is practically
6 what was in the brief.

7 MR. FRAWLEY: I am not quarrelling with
8 your brief. In fact, I suppose by this time you
9 appreciate my principals have precisely the same view
10 of this matter, in part, as your Association has.

11 I am just endeavouring at the moment to
12 throw a little light on my friend's Mr. Hume's suggestion
13 that the cost of research must come from the sale of
14 the drugs, and I put it to you when the drugs are
15 being sold in these two vastly differing channels of
16 trade -- federal hospitals and federal departments,
17 provincial hospitals, and provincial departments of
18 health -- and then the consumer who goes in with the
19 prescription and pays the list price, he must be
20 paying all of the money needed to carry on the
21 research?

22 MRS. SIMS: I would like to ask you one question:
23 if a patient is discharged from the hospital in
24 Alberta and gets a prescription filled, and then runs
25 out, can they go back to the hospital even though
26 they are not a patient at this moment and buy it?

27 MR. FRAWLEY: No. I am very glad you
28 brought that up, because that is the next thing I am
29 coming to. I think in Alberta the poor patient --
30 and I use that in both senses -- is just in the same



1 position as any other province and simply must have
2 its drug therapy carried on at its own expense or
3 at the expense of some social agency, but has no
4 access to the hospital.

5 Mrs. Sims, has your Association had any
6 views of the advisability of throwing open to the
7 general public the dispensaries in large provincial
8 departments of health and federal departments of
9 health or large provincial hospitals?

10 MRS. SIMS: Yes, I think that is covered when
11 we say we think that ought to be considered. They are
12 looking into the needs of hospitalization, but the
13 need of drugs should be covered as well. In the
14 brief I think that is covered.

15 MR. FRAWLEY: Just assuming the situation
16 should come about, and I put it to you in the form of
17 a question to get your opinion: suppose the
18 Alberta Department of Health started to sell penicilin
19 G to the general public having bought it at two cents
20 a tablet, you would hardly expect them to ask twenty
21 cents a tablet at that public dispensary in, say, the
22 university hospital in the City of Edmonton?

23 MRS. SIMS: I would not, no. I can only
24 speak for Quebec.

25 MR. FRAWLEY: Well, put it in Quebec. If
26 the Miniser of Health in Quebec had a program which
27 enabled him to buy penicilin G at two cents a tablet,
28 would you think he would -- assuming he was opening
29 his provincial hospital dispensaries to the general
30 public after a means test or otherwise -- would you



1 think he would consider selling it at twenty cents
2 having bought it at two cents?

3 MRS. SIMS: I would not, no.

4 MR. FRAWLEY: I want to put it to you that
5 I am just as much concerned as your Association with
6 finding out what we can do to get the prices down.
7 I put it to you if the Provincial Department of Health
8 bought the tablet at two cents it would, of course,
9 sell it at something less than twenty cents if they
10 decided to go into that particular type of merchandising?

11 MRS. SIMS: If there is price competition,
12 then the price of drugs is going to come down.

13 MR. FRAWLEY: And there is competition,
14 and the Minister of Health bought the tablet at two
15 cents precisely because there were lots of companies
16 coming to him and bidding to sell at two cents.

17 MRS. SIMS: Yes.

18 MR. FRAWLEY: And I put it to you that the
19 man who sells it at twenty cents is a captive market,
20 that he hasn't got any choice. Nobody offered it
21 at anything less than twenty cents list, at which he
22 sells it less his accepted discount: is that what
23 you understand to be the situation?

24 MRS. SIMS: I would think it is in most things.

25 MR. HUME: Perhaps Mr. Frawley would indicate
26 what the Minister in Alberta does sell them at. It
27 may be interesting to know what markup the province
28 considers fair and reasonable for handling charges
29 and bookkeeping and taxes, or how much they are
30 subsidizing the hospitals.



1 MR. FRAWLEY: I am afraid my friend didn't
2 pay too much attention to what Dr. Ross said. These
3 are distributed free to the people of Alberta, because
4 they are poor people -- old age pensioners, and so on.

5 THE CHAIRMAN: You are not suggesting if
6 they threw their dispensaries open to the general
7 public they would distribute them free to the general
8 public?

9 MR. FRAWLEY: I don't know how soon we are
10 going to reach that.

11 THE CHAIRMAN: We would find out who was
12 paying for the advertising then.

13 I think perhaps you might indicate, Mr.
14 Frawley, when the Alberta Department of Health buys
15 drugs at these competitive prices, they are not
16 buying at retail.

17 MR. FRAWLEY: The Alberta Department of Health
18 is not buying at retail?

19 THE CHAIRMAN: No.

20 MR. FRAWLEY: Oh, no; they are buying at as
21 opposite a thing to retail as you can imagine. They
22 are buying from the manufacturer. They are buying
23 on tender and after bids are made, but they are getting
24 a price I don't know how close to cost. That is a
25 field the green book has some comment about.

26 However, I think it is very commendable
27 that somebody comes forward like this and affords an
28 avenue of discussion, otherwise we would never obtain
29 anybody's opinion about what to do to get the prices
30 down.



1 I am wondering, Mrs. Sims, what your serious
2 views are, for the benefit of the Commission, and
3 whether or not some long term relief might be
4 obtained if we take the manufacturers at their word
5 and get them to sell these drugs in large quantities --
6 50,000 tablets at a time -- because, as you know, the
7 Government of Alberta in its 1961 purchases of this
8 penicilin G bought 400,000 tablets, and its other
9 program, tolbutamide, was 156,000 tablets, and I am
10 seriously asking for your considered opinion as
11 to whether or not along that avenue lies some relief
12 or whether you simply don't agree? I am wondering
13 after throwing the dispensaries of public institutions
14 open, whether the benefit of these low prices could
15 be passed on to the consumer -- whether that is a
16 sensible idea or not? If you don't agree, I would
17 like you to say quite frankly that you don't go along
18 with it.

19 MRS. SIMS: Well, until that is considered
20 in the Province of Quebec, and until I have given it
21 considerable thought myself, I would not have an
22 opinion.

23 MR. FRAWLEY: Until you reach that opinion,
24 do you see any other avenue worth exploring to just
25 bring those prices down? That is all I am concerned
26 about.

27 MADAME VAUTELET: I don't think that this
28 brief here demands a reduction all along the line in
29 the price of drugs. Just as in our hospitals, those
30 who have the means to pay higher prices should not be



1 liberated completely from the need to finance to a
2 certain degree the profits of an industry that won't
3 allow them to let their products go at lower prices
4 in wholesale lots to hospitals. It seems to me when
5 our brief has just presented a suggestion to our
6 province that the lowering of the cost of drugs to
7 the poor and people of low income should be a
8 considered part of the hospitalization plan, that it
9 is not for our Association to recommend to the
10 government how they should go about this before it is
11 further discussed. This is simply a suggestion and
12 the principle that is being presented and for our
13 Association to add the methods by which it should be
14 carried out would be a piece of ~~impertinence at this~~
15 moment.

16 MR. FRAWLEY: I am very much obliged for your
17 answer, Madam Vautelet. In other words, you think
18 if such a program of this sort were embarked upon it
19 should be done through the medium of a means test so
20 that not everybody -- not the millionaires of St.
21 James Street -- would be entitled to get drugs at
22 ~~any price~~ but the poor people who are in need of
23 that -- that these people, provided they could pass
24 a means test, should be entitled to that?

25 MADAME VAUTELET: It should be considered from
26 that angle. I don't think we should go into that at
27 the moment.

28 THE CHAIRMAN: Will you be making an argument
29 on this at some stage, Mr. Frawley?

30 MR. FRAWLEY: Yes, I may be.



1 THE CHAIRMAN: The reason I am asking is.
2 that the suggestion raises some questions. For instance,
3 what would be the effect on the pharmaceutical industry,
4 retail pharmacists, if government departments dispensed
5 prescription drugs at very much lower prices than the
6 druggist would charge? Would it put them out of
7 business? That is one question.

8 Another question is, what would happen to
9 the prices which the Department of Health pays, when
10 the higher prices paid by manufacturers are eliminated?

11 MR. FRAWLEY: In other words, sir, British
12 Drug Houses would not be able to quote Dr. Ross two
13 cents a tablet if he found they were going out at
14 two cents, and there is another aspect of it that makes
15 your question, at least to me, very pertinent: Alberta
16 is a free enterprise province, and I have had no
17 suggestion they would go to the point where they
18 would put the druggist out of business. But, is
19 there any way to break the bonds of what I do regard
20 as a high cost of drugs?

21 Let us find out if there are avenues, and
22 that is why I welcome the fact that these good ladies
23 have come here today to present a brief, and be able
24 to discuss with me -- which is, after all, all it is,
25 a discussion with me -- as to along what avenues lies
26 relief, or must we just suffer the high cost and
27 keep on talking about it and not doing anything about
28 it.

29 MR. HUME: May I make this comment, with my
30 friend Mr. Frawley's permission. Mr. Frawley has,



1 I am sure, endeared himself to the retail pharmacists
2 in Alberta by his remarks this morning, but Mr. Frawley
3 indicated in my presence last Wednesday before the
4 Royal Commission on Health Services that this is the
5 kind of matter he is taking up with that Commission,
6 and I am wondering if that is not the form he should
7 do it in rather than here? That suggestion to Mrs.
8 Sims might better be discussed before that Royal
9 Commission.

10 MR. FRAWLEY: I am surprised Mr. Hume has not
11 thrown that up to me before now. Certainly, last
12 week I asked that Royal Commission if they would be
13 going into the question of the high cost of drugs.
14 I pointed out that this Commission was operating
15 within the confines of the Combines Investigation Act,
16 and they had very frankly and openly stated they
17 were not concerned with the level of prices, nor with
18 whether prices were reasonable, and they assured me
19 immediately they would certainly open up the
20 Commission to discussions of that kind. Mr. Hume
21 says he will meet me there or in any form: it sounds
22 as though we are getting into a quarrel between the
23 Province of Alberta and the rest of the world. In
24 the Alberta legislature last spring a resolution was
25 passed that it was felt the price of drugs was too
26 high, and that in the province alone nothing much can
27 be done, because we don't manufacture drugs, and
28 it is pursuant to that mandate that I have been
29 discussing this with various witnesses. I don't
30 know whether or not or how far we will get with the



1 Hall Royal Commission. I hope we will get a great
2 distance and that relief will come from that, and
3 I commend that information to the Association of
4 Consumers, that the Chairman of the Royal Commission
5 on Health Services indicated he will go into the
6 question of the price of drugs and costs.

7 This is the Quebec English Branch of the
8 Canadian Association of Consumers: is there a French
9 speaking branch?

10 MRS. SIMS: Yes, there is.

11 MR. FRAWLEY: You don't know anything about
12 their intentions to make any representations to
13 this Commission?

14 MRS. SIMS: No, I do not.

15 MR. FRAWLEY: They would have a much larger
16 membership?

17 MRS. SIMS: No, actually they haven't, strangely
18 enough. The English branch is quite large.

19 THE CHAIRMAN: I should state for the record
20 that while under our Act we are not concerned with
21 the prices of drugs as such, or whether they are
22 reasonable, we are concerned with whether the price
23 of drugs is high because of a monopolistic situation
24 or restrictive practices, and that is what we are
25 looking into at the present time: are there restrictive
26 practices, are there monopolistic situations, and
27 the effects they have upon prices and the general
28 welfare of the public. So that, prices are not
29 outside our field of inquiry altogether. We do not
30 look at the question simply from the point of view



1 of high prices because we are not entitled to under
2 our Act.

3 I thought perhaps I might also mention, Mrs.
4 Sims, that the cost of research, while it is in total
5 a very large amount, does not, in accordance with
6 the information the Director obtained in the course
7 of his studies in Canada amount to more than a
8 small percentage of the total costs of the drug
9 industry. Even in the United States, where most of
10 the research for Canadian companies who are
11 subsidiaries of the American companies is done, if
12 we can believe the Kefauver Committee, the cost of
13 research is nothing like as large a percentage as
14 your brief suggests.

15 MRS. SIMS: As we said before, we found that
16 that is one argument that the drug manufacturers
17 always say when you say the drugs should not cost
18 as much as they do. They always say don't forget
19 our research program, and that is the one thing the
20 consumer has in their minds, I have got to pay for
21 research.

22 THE CHAIRMAN: You might look at the cost
23 of advertising and promotion, where a large part of
24 the total cost comes from.

25 MRS. SIMS: Yes.

26 THE CHAIRMAN: Are there any other questions
27 any of the people or representatives of clients
28 might like to ask?

29 MR. McLEOD: You spoke of carrying out
30 some investigation, your organization and you



1 personally. I realize that that would be necessarily
2 fairly limited.

3 MRS. SIMS: Yes.

4 MR. McLEOD: But I wanted to ask you this.
5 In your investigation did you find the conditions
6 as described in the Director's statement, in so far
7 as ---

8 MRS. SIMS: I am afraid I haven't read that.

9 MR. McLEOD: That is all I have sir.

10 THE CHAIRMAN: Madame Vautelet, have you anything
11 you would like to add?

12 MADAME VAUTELET: No thank you.

13 THE CHAIRMAN: Thank you very much Mrs. Sims
14 and Madame.

15 We will have a short break at this time.
16 ---A short recess.

17
18 We will resume the hearing, ladies and
19 gentlemen.

20 We have another brief which was submitted,
21 and which I think might be presented now, by Nordic
22 Biochemicals Limited. Mr. Antoft?

23 SUBMISSION OF NORDIC BIOCHEMICALS LIMITED

24 APPEARANCE: K. Antoft, President

25 MR. ANTOFT: Mr. Chairman, in presenting this
26 brief we had certain reservations regarding the material
27 that the Director of Investigation and Research presented,
28 and this caused us to put together a brief with some
29 very general views on the pharmaceutical industry as
30 seen through the eyes of a company that perhaps operates



1 in a way that is not too common in Canada.

2 The brief I shall now read:

3 Nordic Biochemicals Limited is a Canadian
4 corporation, incorporated under the laws of the
5 Dominion of Canada. All of the members of the Board
6 of Directors are Canadian citizens and all the shares
7 of the corporation are owned by Canadian citizens.

8 The company was organized in 1951 and since
9 that time has engaged in the manufacture, packaging
10 and distribution of pharmaceutical products. The
11 company operates solely in the field of "ethical" drugs,
12 in that its products are promoted solely to the
13 medical profession and are not advertised to the general
14 public.

15 The sales of the company during the year 1960
16 did not exceed \$250,000.00.

17 With this brief background, we should like
18 to comment on the "Material Submitted to the Restrictive
19 Trade Practices Commission, Relating to the Manufacture,
20 Distribution and Sale of Drugs", of which a copy was
21 mailed to our company in February of this year.

22 From the outset, it should be emphasized
23 that we take exception to the generalizations contained
24 in Section C of paragraph 109, Chapter VI. The offending
25 section is a part of a paragraph which classifies Canadian
26 drug manufacturers under various headings and then
27 sets forth the operating procedures under which firms
28 within the different categories allegedly function.
29 As our firm logically belongs under the heading of a
30 "small ethical drug house", we should like to correct



1 this as well as further implications in the material
2 that size dictates the originality, the amount of
3 research carried on, the ability to develop new drugs
4 and important specialties and to market such
5 successfully. The section reads as follows: (Page 61,
6 Section C),

7 "Small ethical drug houses. These
8 vary widely in size but seem to
9 be generally differentiated from the
10 large ethical drug houses not only
11 on the basis of size or volume of
12 business, but also because they do
13 not deal in the newer and more complex
14 drugs (unless they merely purchase such
15 drugs for resale); they carry on little
16 or no research, they are not able to
17 develop new drugs or important
18 specialties and they are unable to
19 carry on elaborate promotional
20 campaigns. The products which they
21 do sell may be of high quality,
22 indeed some have usually been
23 purchased from the large ethical
24 drug houses and are identical with
25 those sold by the latter, but the small
26 firms do not enjoy the same reputation
27 as the large firms."

28 While such a sweeping dismissal of "small
29 ethical drug houses" may have arisen from unreported
30 data in the hands of the Commission, it clearly does



1 not apply to Nordic Biochemicals and it is both
2 damaging and prejudicial to the reputation and morale
3 of the personnel of our company.

4 We would like to set forth in broad outline
5 a few of the facts regarding the research and
6 development work carried out by our company during
7 the past ten years. This will be done by reference
8 to specific quotations from the above statement.

9 A. The statement, "They do not deal in the
10 newer and more complex drugs". - Our company was
11 originally established to commence the manufacture
12 of Corticotropin or more commonly known as ACTH in
13 Canada. In 1951, there was a great scarcity of this
14 important new and complex therapeutic agent, as
15 existing methods of extraction and purification were
16 primitive and inefficient. This supply situation
17 and the importance of ACTH was recognized by the
18 Canadian government, who through the National Research
19 Council, financed Connaught Research Laboratories in
20 Toronto to set up an ACTH manufacture during this
21 period.

22 Our company, in collaboration with a group
23 of Scandinavian drug manufacturers were rapidly
24 able to solve the main problems of the extraction
25 procedure, enabling us to increase the ACTH yield
26 some eight-fold over the previously used methods.
27 At the same time, the new process yielded the much
28 superior Corticotropin, type A, which is of much higher
29 purity than previous preparations. We claim no credit
30 for this original extraction procedure, (which was



1 developed by Dr. E.B. Astwood and his associates in
2 Boston), but it was through our work in Montreal that
3 what had hitherto been an intricate laboratory method
4 became suitable for large-scale processing. As a
5 consequence, a product having approximately 20 times the
6 potency and purity of the International Standard became
7 available to Canadian physicians even before such a
8 product was available in the United States. The
9 greater yields also led to rapidly declining costs of
10 the finished product.

11 In 1953, our company pioneered in the
12 development of a long-acting form of ACTH. As the
13 native hormone is relatively short-acting, therapy
14 formerly required multiple daily injections. Several
15 repository forms of the drug manufactured in the
16 United States had made their appearance on the Canadian
17 market, but all had serious drawbacks. By utilizing
18 an entirely different principle, we were able to make
19 a Canadian preparation which was both more convenient
20 and longer acting. The pharmacological and clinical
21 testing of this new preparation was carried out
22 initially in Montreal and the clinical results were
23 reported in the Journal of the Canadian Medical
24 Association, (Rose, Bram, "Long-Acting Corticotrophin in
25 Allergic Disease", a copy of which is appended hereto).
26 The importance of this Canadian development may best
27 be emphasized by quoting from an American publication
28 the Wayne University Handbook (CORTICOTROPIN: Its
29 pharmacologic effects in man. Detroit 1955) on ACTH.
30 In discussing ACTH preparations available in the



1 United States, a statement appears on page 4: "For
2 Canadian physicians, however, the superior duration of
3 action of carboxymethylcellulose Corticotrophin offsets
4 this defect." That was discussing the defects of
5 various American preparations. "Unfortunately,
6 this material is not available in the U.S.A. at the time
7 of writing....."

8 It should be noted that we do not "merely
9 purchase such drugs for resale", but that the manufacture
10 of Corticotrophin is carried out completely in our own
11 plant in Montreal, utilizing the pituitary glands
12 of hogs slaughtered in Canadian packing plants.

13 During our existence, we have developed and
14 placed on the market other new specialties that are
15 neither trivial in concept nor copies of products
16 developed by other, larger firms. For example, some
17 years ago, we found a practical method of getting
18 hydrocortisone into solution. This principle has
19 resulted in a line of topical hydrocortisone preparations
20 that are widely used because of their enhanced
21 effectiveness and lower cost.

22 B. "They carry on little or no research". - A
23 review of our research activities during the past ten
24 years will demonstrate the injustice of this statement
25 as applies to ourselves. It must be recognized, of
26 course, that only a small part of any research results
27 in commercial products. The philosophy of research
28 which we follow is to permit as much scope as possible
29 to our technical personnel in developing their ideas,
30 improving their professional techniques, and in



1 encouraging original and creative thinking. It is
2 a fallacy to assume that productive research can only
3 be carried out through the much publicized "crash
4 programs", involving armies of technicians and
5 batteries of complex gadgets and computers. On the
6 contrary, it needs hardly be pointed out that many
7 of man's most fruitful discoveries have been made by
8 individuals whose thinking was sharpened by the need
9 to improvise and "make do" with a minimum of resources.
10 In the field of fundamental research, commercial size
11 in itself may often be a handicap. The need to seek
12 approval for each step from management committees is
13 likely to lead to stagnation in this area.

14 It has been the aim of our company to allow
15 our personnel the greatest possible latitude in designing
16 and carrying out original research, supporting them as
17 much as our limited resources permits. As a result,
18 our company is well known in North American medical
19 research centres as a source of several research
20 materials, and also as a place to which investigators
21 may turn for aid in developing techniques or in
22 translating laboratory procedures into production
23 methods. A review of projects that we have undertaken
24 or have participated in would demonstrate that the
25 commercial motive is secondary in most of these
26 endeavours. However, the list is long and filled with
27 "blind alleys" and therefore only a few pertinent
28 examples will be given here.

29 1. Our company has undertaken the extraction
30 of various glandular tissues, for the purpose of



1 assisting investigators exploring the physiology and
2 biochemistry of the human body. Thus we have made
3 extracts of pineal glands, diencephalon, the thymus
4 gland, blood, and other tissues, and have made these
5 extracts available without charge to a large number
6 of people working in various Canadian research centres.

7 2. Human Growth Hormone Project. Since the
8 existence of pituitary growth hormone was first
9 demonstrated early in 1940, many trials had been made
10 with a view to reproducing in man the effects observed
11 in animals from the administration of this hormone.
12 Although many investigators were involved in this
13 research work, the hormone made from animal sources
14 remained without effect when given to man. In 1958,
15 a group of investigators at Harvard University
16 demonstrated that the hormone extracted from monkey
17 pituitaries had a significant effect when injected back
18 into the same species. After this was reported, Dr.
19 John Beck, of the University Clinic at the Royal Victoria
20 Hospital in Montreal, asked us to set up a collection
21 of monkey pituitaries from animals being used in the
22 Salk vaccine program. Although we secured the complete
23 cooperation of the University of Montreal's poliomyelitis
24 vaccine laboratory, the collection of these pituitaries
25 proved to be very cumbersome. It soon became apparent
26 that it would take ~~several~~ years to collect sufficient
27 monkey pituitaries to make extraction worthwhile.
28 Therefore, we began to collect human pituitaries from
29 autopsy cases, in order to test the theory that
30 growth hormone was species specific in man.



1 I should like at this point to read the footnote, which
2 states: "The credit for this original idea actually
3 belongs to one of our detail men, Mr. William Levain,
4 who also was active in making arrangements with Pathology
5 Departments throughout Montreal," as an example of the
6 fact that detail men are not always the negative
7 influences that they are occasionally accused of
8 asserting in the field of drugs. As a result, Dr.
9 Beck became the first clinician to use human growth
10 hormone in a human patient, and he demonstrated that
11 its activity paralleled the results expected from animal
12 experiments. His work has set off a wave of interest
13 in this field, and while the collection of human
14 pituitaries has now become standard practice throughout
15 the world, the initial idea remains a Canadian one.
16 Our company continues to collect pituitaries from
17 pathologists at the major hospitals throughout Canada,
18 extracting the human growth-hormone from these. Due to
19 its extreme shortage, the available supply is allocated
20 through the Canadian Society for Clinical Investigation,
21 and we administer this program solely at our own expense.
22 It is obvious that until another source of starting
23 material is found, this project is purely a research
24 undertaking which is unlikely to have any commercial
25 significance.

26 I may point out that the human growth hormone
27 project was the subject of an editorial in September
28 23rd issue of the Canadian Medical Association Journal,
29 in which the role of our own company and the role of
30 Canadian investigators in general is confirmed, and the



editor of the Journal has been very complimentary in establishing this as another important Canadian first in the field of basic medical research.

3. Miscellaneous pituitary hormone fractions. With the great interest in pituitary physiology, there is a constant demand for various pituitary hormones, as well as for fractions that have not yet been identified as hormones. We offer a nearly complete range of all the known pituitary hormones. In addition, we continually make various fractions whose hormonal action has not yet been characterized. In some instances, we have supplied starting material from which university research workers carry out further fractionation. As examples, two of the substances that are currently of interest to us are the "fat mobilizing" factor from the pituitary, and the factor in the pineal gland area which appears to influence fluid retention.

In most cases we supply these research preparations without charge. If we do not make a particular pituitary hormone ourselves, we may purchase the fraction from one of the members of our Scandinavian research pool. These are imported by us at our own cost and distributed, in most cases, without charge to the interested research group.

C. "They are unable to carry on elaborate promotional campaigns". While we are very loath to spend our limited resources for non-productive promotional purposes, our company has not hesitated to undertake useful and original promotional and educational campaigns. As an example, we may point to the symposium



1 on ACTH which we sponsored jointly with the Hospital St.
2 Francois D'Assise in Quebec City, in 1955. We had
3 become aware at that time that the French language
4 medical literature on ACTH was relatively incomplete,
5 compared to the information available in English.
6 Therefore, we organized a day-long symposium for the
7 benefit of the French speaking doctors in the Quebec
8 City area. Specialists in the field of rheumatology,
9 pediatrics, allergy and endocrinology were brought
10 from Toronto and Montreal to present the latest and
11 most authoritative clinical experience in general
12 practitioners in the area. These proceedings were
13 subsequently published in the medical journal of Laval
14 University, "Laval Medical", and were distributed
15 in booklet form to the French speaking members of the
16 Canadian medical profession, at our cost. Although
17 the expense of this conference and the later
18 publication were perhaps out of proportion to the size
19 of our company, we have enjoyed lasting benefit from
20 the good will engendered by this conference.

21 D. "Small firms do not enjoy the same reputation
22 as the large firms". This is perhaps the most cutting
23 one of all. The matter of reputation is a highly
24 individual thing from one company to another and we do
25 not think that size is a predominant factor.

26 In our own case, our reputation with the
27 Canadian medical profession is certainly as high as that
28 of any other ethical drug house, regardless of size.
29 Conversely, there are several of the large organizations
30 whose reputation for high-power promotion and colourful



1 product claims arouse no feelings of envy.

2 We hope therefore that in its final report,
3 the Commission will modify or eliminate the implications
4 contained in Section C of paragraph 109, that "small
5 ethical drug houses are by definition inferior to
6 "large" ethical drug houses.

7 We should now like to turn our attention to
8 various other points that have occurred to us in a
9 reading of the "Material".

10 EFFECTS OF TARIFFS AND SALES TAX

11 In Chapter 3 of the material, some
12 consideration is given to the impact of tariffs and sales
13 taxes on drug prices.

14 Although tariffs may have a tendency to raise
15 prices, there is evidence that the existing tariffs
16 and dumping duties do have a beneficial influence on the
17 Canadian drug industry. Thus, our company is engaged
18 in the sterile filling of the antibiotic products of a
19 major American manufacturer who does not have Canadian
20 facilities for filling injectables himself. By
21 exporting bulk materials rather than a finished
22 product, he is entitled to send the material into
23 Canada at a low import price, thus effecting a saving in
24 duty and also eliminating the possibility of having
25 to pay dumping duty on an assigned "fair market value"
26 on the finished product. In this case, the dumping
27 duty regulations probably have a tendency to lower the
28 cost of these products, while at the same time giving
29 employment to Canadian manufacturing personnel.

30



1 With regard to sales tax, however, the
2 Canadian manufacturer is in an unfair position in
3 comparison to foreign companies exporting into Canada.
4 As most hospitals buy on a sales tax exempt basis,
5 the collection of sales tax does not enter into such
6 prices. However, many of the materials used in a
7 Canadian manufacturing plant are not eligible for sales
8 tax exemption, even though the end-product may be
9 entirely sales tax exempt. The American manufacturer,
10 however, who sells sales tax exempt goods in Canada is
11 not subject to payment of Canadian sales tax as any
12 part of his manufacturing cost.

13 As an example of how this may operate to the
14 disadvantage of the Canadian manufacturer, we wish to cite
15 a recent specific ruling by the Department of National
16 Revenue in our own case:

17 While all the injectables we manufacture
18 are either specifically exempt from sales tax or
19 usually become so by virtue of their sale to hospitals,
20 it was recently ruled that sterile masks, which are
21 used in sterile filling operations, could not be
22 considered as entering into the process of manufacture
23 directly. Therefore, we are assessed sales tax on these
24 masks at the time of importation. To the extent of
25 this tax, our production cost is increased. I only
26 mention this case. There are other items, but this
27 occasion we have a specific ruling.

28 An American manufacturer, however, dealing
29 in the same type of injectables, which are likewise
30 sales tax exempt, would not be subject to payment of



1 sales tax on the cost of these masks in his factory.
2 To this extent, he receives preferred treatment by
3 carrying on his manufacturing operations outside of
4 Canada. Although masks are a minor cost item, it is
5 only one of a large class of laboratory supplies that
6 do not qualify for tax-free purchase.

7 Ownership of pharmaceutical manufacturing houses.

8 It must be admitted that the non-Canadian drug
9 manufacturers have in large measure contributed to the
10 rich store of valuable therapeutic weapons that the
11 Canadian medical profession has at its disposal.
12 Because it is controlled from outside of Canada,
13 marketing practices and pricing are factors that fall
14 largely beyond the control of Canadian market pressures
15 or governmental control. In the main, purely
16 Canadian influences on prices are usually in an upward
17 direction, due to the tariff and sales tax which is
18 added to imported goods.

19 It appears that the Director of Investigation
20 and Research has recognized that manufacturing costs of
21 most drugs marketed in Canada are not easily subject to
22 scrutiny by Canadian authorities. Therefore, since
23 any possible abuses are largely originated outside of
24 Canada, it would perhaps be unfair to call the few
25 solely Canadian companies to account for those sins
26 of whose fruits they only enjoy an insignificant
27 fraction. It would perhaps be more useful to consider
28 methods of encouraging the development of a native
29 pharmaceutical industry whose behavior would be solely
30 dictated by Canadian conscience and Canadian law. We



1 will have specific recommendations in this field in a
2 later part of this brief.

3 The role of the retail druggist in Canada

4 Much has been made in the popular press,
5 particularly as a result of the so-called "Kefauver
6 Committee" in the United States, of the differences
7 in cost of retail drugs in North America as compared
8 to various European countries, and the same subject
9 is raised in the "Material". The organization of
10 European drug distribution differs greatly from that
11 in North America and these differences are necessarily
12 reflected in the price that the consumer pays for the
13 retail package.

14 In many European countries, the retail
15 pharmacist does not operate as a free competitive
16 agent. In Denmark, as one example, it happens to be
17 one we have enough data on to discuss, the owner of
18 a pharmacy derives his authority to operate his drug
19 store by Royal resolution, the number of pharmacies is
20 limited by law, locations are rigidly controlled by the
21 Home Ministry, and prescription pricing is determined by
22 the official schedules laid down by governmental
23 authorities.

24 This rigid framework has led to Danish
25 pharmacies developing in a completely different direction
26 than that commonly seen in North America. Thus, in all
27 of Denmark there is one pharmacy for every 13,000
28 persons, while in Copenhagen the ratio is about one to
29 each 16,000 of population. This is in contrast with
30 the Canadian average of only 3,624 persons per pharmacy



1 reported in 1960 (see page 66 of the "Material"). The
2 Danish pharmacies are, in fact, small pharmaceutical
3 factories, equipped to carry out their own tableting,
4 filling of injections, ointment preparation etc.,
5 but they are strictly limited to the sale of
6 pharmaceuticals, and such sources of income as soda
7 fountains and department store merchandise are not
8 permitted.

9 THE CHAIRMAN: Mr. Antofit, you mean they
10 sell nothing but prescription drugs?

11 MR. ANTOfT: That is right.

12 THE CHAIRMAN: Nothing but prescription drugs?

13 MR. ANTOfT: They do have over-the-counter
14 pharmaceuticals, but there are a very limited portion.

15 THE CHAIRMAN: They don't sell toothpaste or
16 things like that?

17 MR. ANTOfT: No, they don't sell toothpaste.
18 There are separate stores that sell generally cosmetics
19 and this type of thing, such as toothpaste and shampoos
20 and that sort of thing. These separate stores don't
21 sell prescriptions or deal in medicines in any form.

22 The net effect of controlled prices and local
23 manufacture is that the retail mark-up is much lower
24 than in Canada. It is interesting to note that in 1958,
25 a total volume of 20.6 million prescriptions were filled
26 by Danish pharmacies at a total cost of \$19,500,000.
27 Thus, the average cost of a prescription was less than
28 \$1.00, while in Canada, the figure in the same year
29 was \$2.78.

30 This information is entered in our brief not



1 with a suggestion that this system is preferable to the
2 one that prevails in Canada, but purely to point out
3 that in comparing prices in different countries, many
4 factors beyond the avarice of individuals or corporations
5 may enter into the picture.

6 It is quite apparent that the Canadian
7 pharmacist is faced with a very thorny dilemma. He is
8 rapidly losing his professional standing, as the trend
9 to pre-packaged drugs calls upon less and less skill
10 in dispensing. It is noticeable in all Canadian
11 drug stores that the facilities required for compounding
12 are rapidly diminishing. The serious pharmacist who
13 is interested in his profession often leaves the
14 retail field and enters industry, hospitals, or
15 government bodies, where he can exercise more of
16 his academic qualifications. The result is that retail
17 drug stores are becoming more the domain of
18 merchandisers, whose success is determined by their
19 use of modern promotional and merchandising techniques
20 rather than by their knowledge of pharmacy.

21 Although the Canadian Pharmaceutical
22 Association is highly disturbed at the loss of
23 professional prestige which they feel their members
24 have suffered in the eyes of the public, they apparently
25 do not appreciate that this is the price that they must
26 pay for becoming successful merchants. Perhaps the
27 Canadian Pharmaceutical Association is itself
28 contributing towards emphasizing the role of the
29 druggist as a business man. Any issue of the Canadian
30 Pharmaceutical Journal shows that preoccupation with the



1 purely commercial side of the profession receives a
2 large measure of editorial attention, and certainly
3 is the theme of practically all the advertisements
4 directed at the practicing pharmacist. As an example,
5 the March 1961 volume of this publication contains 21
6 full pages of advertising, more or less. Most of
7 these advertisements are by drug manufacturers. Those
8 that deal with specific products emphasize the profit
9 advantage in "pushing" the product concerned. The
10 phraseology is illustrative of this and the following
11 are examples, each culled from a separate advertisement
12 in this issue: "High margin medication" - "You profit
13 from rapid turnover and repeat business" - "New
14 profits to you" - "Another profit producer" - "Traffic
15 builders for you" - "Another potential best seller" -
16 "Recommend them for increased profit" - "Cash in on
17 these.....deals" - "Leading seller" - "High profit.....
18 products". The whole tone of advertising directed at
19 the retail pharmacist is well summarized on the back
20 cover ad of this issue: a list of the advertiser's
21 products are set forth in an attractive box whose border
22 is formed of \$\$\$\$ signs!

23 The druggist who is striving for professional
24 stature would do well to compare the advertisements to
25 which he is exposed in his own trade journals with those
26 that the same drug manufacturers place in the journals
27 directed at the medical profession. In the latter,
28 advertisements suggesting that the reader will derive
29 material profit from prescribing specific product is,
30 of course, unheard of, and every pharmaceutical



1 manufacturer knows that such ads would be rejected
2 out of hand by the editorial board of every medical
3 journal. It is obvious that the profession of
4 pharmacy will never achieve its desired stature unless
5 it is prepared to accept ethical restraints similar
6 to those imposed by the medical profession on its own
7 membership.

8 THE CHAIRMAN: There is a difference, the
9 doctors are not selling the drug. The druggist is.

10 MR. ANTOST: Yes, but the appeal of the
11 manufacturers to the druggist is if you sell this
12 drug you will make a profit. The manufacturer does
13 not appeal to the medical profession on the same level.

14 THE CHAIRMAN: It appeals to the medical
15 profession on the basis if he prescribes this drug it
16 will be beneficial for his patient.

17 MR. ANTOST: That is correct, and I think we
18 could very well, as manufacturers, we could very well
19 adopt for ourselves the same kind of tactics in our
20 advertising directed at the pharmacists. We, as
21 manufacturers, are anxious that the pharmacist shall
22 retain or build his professional stature. I think
23 we are debasing him by appealing solely to his
24 commercial motives in doing business. I think that
25 the pharmacist has a role in easing and helping the
26 doctor to assess new products, but if he is over-
27 whelmed with this type of promotional approach this
28 pharmacist is very likely to put commercialism ahead
29 of what he would otherwise do to influence the doctor
30 in prescribing the newer developments in drugs. He



1 has more time to follow them than the doctor has. This
2 is the point that I am trying to make in this section.
3 I think this has come about both by the manufacturers
4 and the retail druggists being somewhat lax in this
5 respect and have allowed this situation to develop over
6 the years.

7 RETAIL PRICING - Retail pricing policies are treated
8 at some length in the "Material".

9 A large part of the resentment in the public
10 mind about drug prices results from the variation in
11 the price of an identical prescription, from one drug
12 store to another. Retail druggists have wrestled with
13 this problem of pricing for many years and numerous
14 formulae have been suggested to achieve uniformity.
15 The predominant thought is that the price of a
16 prescription should reflect not only the cost of the
17 ingredients, but also the "professional fee" of the
18 druggist filling the prescription, and varying amounts
19 and percentages are therefore added. For this reason,
20 the manufacturer has only a very partial influence on
21 the ultimate cost of his product to the patient. In our
22 own case, we set a list price on each of our products,
23 and on this list price, we grant a 40 per cent discount
24 on direct sales to hospitals, pharmacists and doctors,
25 (with additional discounts to wholesalers and
26 distributors). In various ways, however, we become
27 aware that our products are often sold to the consumer
28 at prices well above these "list prices". A recent
29 example occurred when a package was returned to us for
30 credit. In ink, it carried a price notation "\$3.75".



1 As the list price on this product is \$1.40, the
2 druggist would have paid us \$0.84 if he had bought it
3 from us directly. (As it happens, we were able to
4 identify this by the lot number as being a sample, which
5 we found that we had sent to him without charge several
6 years earlier!)

7 As a manufacturer, we are naturally concerned
8 with retail pricing policies by the drug stores, as the
9 excessive "loading" of a retail price will work to
10 diminish our market. Furthermore, such practices will
11 tend to further impair the consumer's view of the
12 manufacturing industry, as the blame for high prices
13 of drugs is usually attributed to the greed of the
14 manufacturer.

15 It is difficult to envisage any legislative
16 action which would contribute to a solution of this
17 problem. However, we feel strongly that the druggist,
18 if he feels he is entitled to a professional fee,
19 should list this fee as a separate item on his
20 prescription bill to the patient. In this way, he
21 would emphasize his professional function and the
22 question of his fees would be divorced entirely from
23 the discussion of high drug costs.

24 MANUFACTURER'S PRICING POLICIES - When Nordic Biochemicals
25 Limited was established in 1951, we approached our
26 responsibilities with what appears in retrospect to be
27 naive idealism. We assumed that all that was necessary
28 to thrive and expand in the Canadian drug manufacturing
29 industry was to offer the best possible product at a
30 reasonable price, in the expectation that within a very



1 short time we would be operating at capacity. It
2 was thought that advertising could be held to simple
3 announcements in one or two of the main medical
4 journals, announcing that our products were available.
5 No provisions for direct mail promotion, an army of
6 detail men, or huge sampling programs were envisaged.
7 While this philosophy was operative, the company
8 teetered on the brink of disaster, but only with
9 reluctance and by degrees did we accept the "facts of
10 life", and the company finally began to prosper. It
11 was rapidly discovered that although doctors publicly
12 deplore the mass of direct mail literature, a sales
13 volume on practically any product could be created by
14 advertising it by mail providing it is done persistently
15 and massively. Detail men are an expensive method of
16 securing sales, but without them, cobwebs grow on the
17 order desk. Thirdly, in order to detail, a
18 representative must usually bribe" his way into the
19 doctor's presence by the offer of free samples in
20 generous volume. The drug house who neglects any one
21 of these three sales methods invites its own decline.
22 At the same time, the flamboyant overuse of such sales
23 methods has led to increasing coolness between
24 responsible sections of the medical profession and the
25 pharmaceutical industry as a whole. As a consequence,
26 the channels of communication between the doctor and
27 the drug manufacturer deteriorate, and the cost of
28 drug promotion consequently increases. More and more
29 mail is needed to put across a given idea, more and
30 more time is wasted by detail men in attempting to see



1 doctors who are determined to see as few of these
2 salesmen as possible, and more and more samples are
3 shovelled out in an attempt to catch the eye of the
4 men who write prescriptions.

5 Although Nordic Biochemicals has been forced
6 to adopt some of this sales pattern, we have attempted
7 to maintain a sense of proportion in doing so. Our
8 direct mail is designed to be informative rather than
9 persuasive. Our detail men are required to be experts
10 in our own particular field, so that their advice may
11 be followed with confidence. As much as possible, we
12 attempt to channel whatever sampling we are required
13 to do into avenues where indigent patients will
14 benefit.

15 Currently, these three avenues of sales
16 promotion, plus a very limited journal advertising,
17 costs us approximately 35 per cent of our gross sales.
18 While we would much rather spend this money on research
19 and development or on reducing our prices, we know from
20 experience that without these sales expenditures, there
21 will be no sales.

22 While sales promotion is the largest single
23 factor reflected in our price structure, it should also
24 be noted that we operate in a field where the cost of
25 raw materials is very high. In the manufacture of ACTH,
26 our starting raw product is the pituitary gland of the
27 hog. These currently cost us \$700.00 per kg. in the
28 dried state, when bought from the slaughter houses.
29 I might note this was written in the month of March.
30 They now cost \$1100.00 per kg. in the dried state bought



1 from the slaughter houses. In the actual extraction,
2 there is a great element of risk, as the yields may
3 vary from 50,000 I.U. per kg. of glands, up to 140,000
4 I.U. The cost of assaying ACTH is also very considerable,
5 in that an assay of a Master Lot may require up to 150
6 rats, each one of which must have its pituitary removed
7 by a very intricate operation.

8 Finally, there are the costs of quality
9 control, research and development. In our case, these
10 account for approximately nine per cent of our gross
11 sales. I should say this figure of 9 per cent is the
12 direct cost that we can attribute directly to control
13 and research activities. In a small organization
14 such as ours there is a great deal of overlap of
15 production personnel who may assist our control personnel
16 so that this nine per cent is subject to revision
17 upwards. We have tried to break it down for our own
18 purposes as we have no particular necessity to do so.

19 THE CHAIRMAN: It is really more than nine per
20 cent?

21 MR. ANTOST: Really more than nine per cent.
22 If we didn't carry out quality control research and
23 development then our overhead cost however, our
24 fixed cost would be reduced by nine per cent.

25 SUMMARY AND RECOMMENDATIONS

26 We have attempted to correct the impression
27 that new ideas are the prerogative of the larger,
28 usually foreign-based pharmaceutical manufacturers.
29 We have attempted to point out some of the factors
30 that not only operate to determine drug prices, but that



1 also influence the public's opinion of drug prices:

2 We have stressed the high cost of communicating with
3 the doctor and have pointed out that this cost is
4 likely to increase unless more rational and direct
5 communication is established between the drug
6 manufacturers and the doctors.

7 Relations among the pharmaceutical industry,
8 the retail druggist, and the medical profession, should
9 be studied by the three groups. We feel there is little
10 that can be accomplished in this area by any governmental
11 action.

12 A question of whether or not additional
13 regulation or legislation is necessary to modify drug
14 prices will remain largely academic while the major
15 part of Canada's drug needs are supplied by parent
16 sources beyond the jurisdiction of Canadian laws and
17 market influences.

18 It is submitted that a more rational approach
19 to the problem is to develop means of encouraging
20 the growth of Canadian-based pharmaceutical manufacturing.
21 While foreign ownership by itself cannot be considered
22 detrimental to Canadian manufacturing, it is important
23 that such operations should be allowed to operate with
24 as much commercial independence of the parent company
25 as possible. When a Canadian subsidiary is purely a
26 branch factory with all policies decided in a head
27 office located outside of Canada, such organizations
28 are vulnerable to decisions that may not be in Canada's
29 national economic interest. Thus, the recent closing
30 of one of the major basic manufacturers in the



1 pharmaceutical industry in Canada turned out to be
2 disastrous for several hundred people who were dependent
3 on this plant for their livelihood. While it may be
4 good policy to close down a branch factory in times
5 of contracting sales, one may speculate if an independent
6 Canadian company in similar circumstances would not
7 have had great incentive to rationalize and diversify
8 its production, rather than shut down completely.

9 To encourage the growth of the Canadian
10 pharmaceutical industry would increase competition with
11 the resulting prospect of lowering prices. The only
12 basis for any sound industry, however, is in the
13 development of new ideas and new products. This requires
14 that existing Canadian industries devote more of their
15 resources towards both basic and applied research.

16 On the part of government, such objectives
17 could be encouraged by permitting bodies such as the
18 National Research Council to work more closely with
19 industry. The United States example of the National
20 Institutes of Health's Cancer Screening program is one
21 method in which this could be accomplished. Under
22 this later program, research and development contracts
23 are farmed out to private pharmaceutical companies,
24 and promising results have already developed from
25 this approach.

26 Many of the medical research programs that
27 are now being carried out at universities could well
28 be broadened to enlist the cooperation of pharmaceutical
29 research laboratories. In this way, incentive would
30 be given to scientists to enter Canadian industry and



1 thus enlarge the horizon of Canadian manufacturers.

2 Our position is weak in competing in mass production,
3 but this deficiency could certainly be overcome by
4 employing more inventive genius.

5 THE CHAIRMAN: Mr. Antoft, do you wish to make
6 any comments on the brief, or add anything to it?

7 MR. ANTOFT: I would like to make one. I
8 presented a somewhat similar brief in June at the
9 hearings of the Ontario legislative committee on
10 drug prices, and at that time I made the unfortunate
11 error of including a very minor incident in which we
12 felt that a druggist had unreasonably raised the price
13 of one of our products. Now, the wire services of the
14 newspapers carried a very fair and comprehensive report
15 of my brief, but as happens at times, the newspaper
16 office digested out of this story that the poor little
17 pharmacist had literally given a black eye to the whole
18 industry, and in many parts of the Dominion of Canada
19 my brief, which was essentially the same as this, was
20 hailed as being an attack, or an attempt to put the
21 whole blame for the high drug prices on the unethical
22 conduct of the retail pharmaceutical profession.

23 I would like to strongly emphasize that this
24 is not the case. I feel that the Canadian pharmaceutical
25 profession, as a whole, act in a highly ethical way.
26 We as manufacturers should be giving them more support
27 in trying to improve their position in their struggle
28 to counteract this so-called loss of stature.

29 I would also ask for the members of the press
30 that are present, that they do whatever they can to see



1 that a similar distortion does not occur today. As
2 far as these hearings are concerned, I may respectfully
3 suggest that the fear of similar episodes occurring
4 could very possibly be the reason why some manufacturers
5 are reluctant to speak openly. It is my own feeling
6 that this Commission here would perhaps have gotten
7 more frank and more pertinent information if they
8 were able to offer some protection of the witnesses
9 towards this sort of thing happening that happened in
10 my own case. I had some very irate letters from
11 druggists, who felt I was maligning the profession, and
12 some of my salesmen were very unhappy, because they
13 felt they were receiving a cool reception, and I would
14 like to make this observation for what it is worth in
15 the further work of this Commission.

16 THE CHAIRMAN: Thank you Mr. Antoft. It is
17 very obvious to the Commission that you have thought
18 about these problems at considerable length. I notice
19 that your advertising and promotion, at about 35 per
20 cent of your gross sales, just about hits the average
21 on the nail for the industry as a whole?

22 MR. ANTIFT: That is right.

23 THE CHAIRMAN: I was wondering, with sales of
24 only \$250,000.00, what with all the unpaid research work
25 you are doing, how do you manage to navigate?

26 MR. ANTIFT: Of course, we hope that that
27 figure is not a static one.

28 THE CHAIRMAN: Your company is a Canadian
29 corporation, entirely operated by Canadians. I gather
30 from what you say in the brief that there is some



1 association with people in Denmark?

2 MR. ANTOfT: Yes, we have a research pool with
3 a group of Scandinavian companies, in which we exchange
4 ideas. It is not a very formal basis. It is more
5 on the basis of personal friendship and this type of
6 thing, but it does enable us to broaden our horizon
7 and have available to us ideas that would be beyond
8 the scope of our own somewhat limited staff and
9 resources.

10 THE CHAIRMAN: So in no sense is there
11 any parent and subsidiary relationship at all?

12 MR. ANTOfT: No.

13 COMMISSIONER CARIGNAN : As far as the
14 statement made by the Director on page 61, and quoted
15 by you, is concerned, it may well not apply to your
16 company, but it may be quite right as a general
17 statement. Do you know many small ethical drug
18 manufacturers who carry researchers? Do you feel
19 that there are many of them that deal in new drugs
20 and so on?

21 MR. ANTOfT: I do think as a generalization
22 this is unfair to more companies than my own. I
23 cannot speak for other than our company, but I would
24 expect that there are other companies who would feel,
25 if they had seen the statement, would be moved to make
26 similar comments to what I have made.

27 COMMISSIONER WHITELEY: What part of your
28 sales do you estimate are made through retail drug
29 stores?

30 MR. ANTOfT: Roughly about 40 per cent.



1 COMMISSIONER WHITELEY: These costs you
2 refer to on page 15 of your brief, do they form about
3 the same proportion of your sales to drug stores as
4 through other channels?

5 MR. ANTOFT: I should make it clear that
6 we sell generally to what are called the usual channels.
7 We sell to drug wholesalers. I thought perhaps your
8 question was related to what proportion ended up in
9 retail pharmacists, compared to what ended up in
10 hospitals. Our basic selling price is the same,
11 whether we were to sell directly to a drug store or to
12 a hospital or a government agency. Everyone would
13 get the same level of wholesale price. The only
14 people who get an additional discount are the drug
15 wholesalers, who carry out the function of stocking,
16 merchandising, and so on, but if we sell directly, we
17 sell ourselves from our list price we have a discount
18 of 40 per cent which applies to every category which
19 is entitled to buy at wholesale.

20 THE CHAIRMAN: That is just the wholesale
21 discount?

22 MR. ANTOFT: We have a list price on which
23 we extend the 40 per cent discount to drug stores,
24 hospitals, and to government agencies, and to doctors
25 who buy direct from us.

26 THE CHAIRMAN: You have an additional discount
27 when you sell to wholesalers?

28 MR. ANTOFT: Yes sir.

29 COMMISSIONER WHITELEY: On page 13, under the
30 heading: "Retail Pricing", by implication you are



1 suggesting that uniformity of retail prices would be
2 a desirable goal. Is that the implication you intended
3 to convey?

4 MR. ANTOFT: No, this is not my opinion. I
5 do not think that uniformity would be a good thing.
6 I am merely reflecting the observation that a lot of
7 discussion in the pharmaceutical journals over the
8 past few years has been devoted to finding a common
9 basis, ~~so that~~ that there won't be so much discrepancy, and
10 apparently the public won't criticize the druggist for
11 one druggist overcharging and another one for cutting
12 prices. I do not believe that it would be a good
13 thing that druggists follow a set pattern. I don't
14 believe that that would be healthy or desirable, but
15 there was a lot of discussion in the pharmaceutical
16 journals amongst the druggists of how to achieve such
17 a state of affairs.

18 COMMISSIONER WHITELEY: On page 11 you
19 ~~discuss~~ the situation in Denmark, and you point out
20 the different methods of operation in the retail drug
21 field. You give as an example the average cost of
22 a prescription in Denmark as compared to Canada. What
23 part of that difference would be accounted for by
24 reason of the difference in retail markets?

25 MR. ANTOFT: I think first of all that there
26 are a lot less number of packaged drugs sold through
27 Danish pharmacies. The druggist makes up a lot of
28 his ointments and tinctures, and even injectibles on
29 the premises, and I think it is probably because of,
30



1 first of all that their habits of medication are simply.
2 I believe that in Canada and the United States, it is
3 my own personal belief that there is probably a tendency
4 on the part of doctors to over-prescribe many patients
5 who arrive in the doctor's office, with whom there may
6 be very little wrong, because of that they are
7 concerned about some emotional problem and it has
8 become the practice in Canada and elsewhere to prescribe
9 something for this patient. I think that probably the
10 same patient in Denmark would walk out of the doctor's
11 office with more advice and less prescription.

12 THE CHAIRMAN: Sometimes the doctors here
13 would say that the psychological effect of that is
14 good.

15 MR. ANTTOFT: Yes, this is possibly true, but
16 on the other hand sometimes they prescribe expensive
17 items ---

18 THE CHAIRMAN: I suppose your comments about
19 the greater simplicity of prescribing in Denmark
20 means that there are very much fewer packaged and
21 brand name drugs sold?

22 MR. ANTTOFT: Yes, I think that there are
23 fewer products that are put out under the same name,
24 that is basic compounds that are put out under the
25 same name.

26 THE CHAIRMAN: So many of the patented drugs
27 are made up in dosage forms?

28 MR. ANTTOFT: Yes sir.

29 THE CHAIRMAN: Have any of the counsel questions
30 to ask?



1 MR. HUMS: Do I understand that your reference
2 on page 15 with respect to your promotion, you say
3 that: "We know from experience without these sales
4 expenditures, there would be no sales." Is your
5 point this, that this amount of this percentage you
6 have found as a managerial decision has been necessary
7 to keep your company going, and if you say cut it
8 in half for some purpose or other, that you would
9 seriously figure that your sales would decrease by an
10 important percentage?

11 MR. ANTTOFT: Yes, very definitely.

12 MR. HUMS: And this is the product, I suppose,
13 of the way we do business in Canada?

14 MR. ANTTOFT: That is correct.

15 MR. FRAWLEY: You told the Commission that
16 40 per cent of your sales were through retailers.
17 Perhaps you could clarify that a little bit, because I
18 do not quite understand it.

19 MR. ANTTOFT: It is an estimate based on what
20 percentage of our sales go to wholesale houses whose
21 main outlets are retail drug stores.

22 MR. FRAWLEY: Could you give an approximation
23 showing the whole 100 per cent?

24 MR. ANTTOFT: I would say that the other 60
25 per cent is represented by sales directly to hospitals
26 and government institutions.

27 MR. FRAWLEY: Sixty per cent to hospitals and
28 the like, and then 40 per cent to either retailers
29 direct or to wholesalers who then pass them on to
30 retailers?



1 MR. ANTOST: Yes, this is my estimate.

2 MR. FRAWLEY: On page 13, you do refer to
3 the variation in the price of an identical prescription
4 from one drug store to another. Supposing that I had
5 a prescription from my physician for five CC of
6 Duracton, which is one of your injectibles, I could
7 take that prescription, and if I was so minded I could
8 go from drug store to drug store in Montreal, and I
9 would find a great variety of prices. Is that what
10 you mean?

11 MR. ANTOST: Yes, I think you would find a
12 variety of prices. Yes, I wouldn't say that it was
13 necessarily a large one.

14 MR. FRAWLEY: Well, I was wondering how much
15 it would vary. That would be sold to the retailer
16 either by you direct, at what is called the list price?

17 MR. ANTOST: Yes.

18 MR. FRAWLEY: And he has, as I understand it,
19 a margin of 40 per cent?

20 MR. ANTOST: Yes.

21 MR. FRAWLEY: Assuming, which apparently is
22 far from the fact, but assuming that those five cc's
23 cost me a dollar. He has forty cents to give and
24 take, to come and go on?

25 MR. ANTOST: Yes.

26 MR. FRAWLEY: Plus perhaps the additional
27 prescription fee?

28 MR. ANTOST: Yes.

29 MR. FRAWLEY: And you find that in Montreal
30 that there is quite a movement in that forty per cent,



1 that some of the druggists would be content to take a
2 markup of 30 per cent on this injectible of yours?

3 MR. ANTOST: Well, I would rather not make a
4 general statement about it, because we have not done
5 a survey of what sort of prices are being charged, but
6 I do know of patients who are on long term treatment
7 with Duracton from whom that a druggist knows that
8 he is going continually to be supplying Duracton to
9 him, and he has taken a very nominal markup.

10 MR. FRAWLEY: He would give him almost on a
11 volume basis?

12 MR. ANTOST: That is correct.

13 MR. FRAWLEY: And he would take that into
14 account?

15 MR. ANTOST: Yes, but I am not prepared to
16 say to what extent this is a general practice.

17 MR. FRAWLEY: But the statement in your brief
18 on page 13, you can relate it to your products sold by
19 retail in Montreal?

20 THE CHAIRMAN: Mr. Frawley, I think to get
21 the figures right, it would seem to me that if the
22 price the druggist actually paid was a dollar, the
23 list price would be \$1.66 and two-thirds, and 66 and
24 two-thirds cents is what he would have to play with.

25 MR. FRAWLEY: If the list was a dollar, he
26 would pay sixty cents?

27 MR. ANTOST: Yes.

28 MR. FRAWLEY: And he would have forty cents
29 to play with?

30 MR. ANTOST: Yes.



1 MR. FRAWLEY: And we have been told, and
2 the Director's Report implies that almost all of them
3 regard the dollar as the price they charge?

4 MR. ANTOFT: Well, I may comment that in a
5 high-priced drug, such as Duracton for example, where
6 the druggist has a small package and a large volume,
7 that he would probably be more inclined to assist
8 the patient who is on long term therapy, in giving
9 him a lower price than say in the price of a product
10 that is listed at \$2.50. It is probably more likely
11 that this \$2.50 would be kept more across the board,
12 rather than the \$9.00 in the case of Duracton.

13 MR. FRAWLEY: You speak about the kind of
14 advertising that goes into medical journals as against
15 the kind that goes into pharmaceutical journals. I
16 seem to recall looking at my brother's copy of the
17 Journal of the American Medical Association. He is
18 a physician in California. That there were a number
19 of rather flamboyant advertisements in the pages
20 which may not have been addressed to the doctor,
21 advertising which you could very well call puffing
22 the product. Have you not found that?

23 MR. ANTOFT: Yes, I agree, and I would think
24 that the American Medical Association has been
25 conscious of this, and has been reviewing advertisements
26 more, with a much more careful eye to the claims that
27 are made. However, I don't think that, I am not
28 particularly referring to flamboyant therapeutic
29 claims. I am referring to the fact that a particular
30 remedy or drug is offered to a druggist, not because



1 of its inherrent characteristics or its possible
2 benefits to his patient, but because by selling a
3 dozen of these he is going to make more money than
4 by selling a dozen of a competitive product, and
5 this is a point where I don't think you would find
6 a similar situation in medical journals, even some
7 which have more relaxed advertising policies than
8 others.

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1 MR. FRAWLEY: Just speaking of the role of
2 the retail pharmacist and druggist in the drug store,
3 he has, as you understand, nothing more than 30 cents
4 to cover his output, operating expenses, operating
5 his shop, his dispensary in any event. That is
6 pretty well the fact; isn't it?

7 MR. ANTOFT: Well, of course, the druggist
8 because he has only a limited number of people that
9 he can serve he, in Canada, is unable to live purely
10 on his prescription department so you have the tendency
11 of drug stores becoming more and more small department
12 stores, selling all kinds of goods.

13 MR. FRAWLEY: In some large cities we have
14 dispensaries.

15 MR. ANTOFT: Oh, it is my observation that
16 these are not the most prosperous of the drug stores.

17 MR. FRAWLEY: Well, I don't know.

18 THE CHAIRMAN: I suppose, in addition to the
19 forty cents he would have a prescription fee?

20 MR. ANTOFT: Yes, if he adds the prescription
21 fee. My feeling, of course, is this should be shown
22 as a professional -- the pharmacist states he is
23 performing a professional function and I think that
24 he should go out of his way to convince the public
25 of this and he should set forth on the bill saying
26 this is what I charge for my professional function
27 apart from my function as a dealer in merchandise.
28 I offer you this service for which I am entitled to
29 be paid. If this were done we wouldn't confuse
30 discussions about pricing at the retailing level with



1 discussions of pricing at manufacturing.

2 MR. FRAWLEY: That is right. All the retail
3 pharmacists don't charge a professional fee?

4 MR. ANTOFT: That is correct.

5 MR. FRAWLEY: As to those who don't charge
6 a prescription fee, I simply put it to you, that the
7 only elbow room he has in between the dollar that is
8 listed by the manufacturer as the list price and the
9 sixty cents he is actually paid for it?

10 MR. ANTOFT: Yes, that is correct.

11 MR. FRAWLEY: I wouldn't think that the
12 retail pharmacists, by and large could be accused of
13 being any important factor in keeping up the price of
14 drugs?

15 MR. ANTOFT: I agree, he is not an important
16 factor.

17 MR. FRAWLEY: If they are too high, one must
18 search some other place.

19 MR. HUME: May I follow that, the inquiry being
20 principally concerned, Mr. Antoft, with ethical
21 drugs and your reference to the kind of advertising
22 where the druggist is urged to promote the sale of a
23 drug, that surely must relate to the proprietary or
24 patent aspect of drugs?

25 MR. ANTOFT: There is a certain amount of
26 overlap. Unfortunately I didn't bring this particular
27 copy with me, but there are announcements of new
28 drugs in which they say, this is now being heavily
29 detailed to the doctors in your area. Make sure
30 that you have the material on your shelves ready to



1 meet the anticipated heavy demand. Again the emphasis,
2 it seems to me in these types of advertising dealing
3 with ethical drugs has always been to the dollar and
4 cent advantage of having this stock on your shelves
5 rather than to explain or attempting to explain
6 through the method of advertising what this new
7 development is all about.

8 MR. HUME: If I require your product could
9 I buy it, go into a pharmacy and buy it or must I have
10 the prescription, your particular product?

11 MR. ANTIFT: Some of our products are on
12 prescription and some are not.

13 MR. FRAWLEY: May I ask another question.
14 I was interested in these dispensaries. Have you any
15 idea at all of the approximate percentage of
16 prescriptions that are filled by these dispensaries
17 in Canada as against the ordinary garden type drug
18 store with its soda fountain and barbecue and everything
19 else?

20 MR. ANTIFT: No, I am sorry I don't. My
21 statement may have been a little too broad. It has
22 been my observation that there seem to be less and
23 less of these purely dispensing drug stores in existence.
24 From year to year you would see one drop out here
25 and there.

26 MR. FRAWLEY: More and more medical dental
27 buildings have been built in Canada's big cities and
28 everyone of them has a dispensary, perhaps two.
29 There are some I know where you have to stand in
30 line for half an hour to get your prescription filled.



1 It seems to me that perhaps the bulk is a little
2 larger in the actual volume of prescriptions filled
3 than perhaps you have been led to believe, but in
4 any event these dispensaries also have the list minus
5 forty per cent.

6 THE CHAIRMAN: Mr. Antoft, in your brief
7 you make a number of comments on advertising and
8 promotion which seem to indicate that you don't just
9 like the extent to which these things were carried
10 on. I wonder if these comments have in your view --
11 this is what I want you to answer -- whether you
12 think this is putting it too strongly, whether you
13 feel the manufacturers have got into a kind of
14 unfortunate ratrace in having to have more and more
15 detail men, more and more fancy advertising? Would
16 that be putting your views too strongly?

17 MR. ANTOST: I don't think that would be
18 putting it too strongly. I deplore this. I think
19 it has developed into a ratrace. I hope our industry
20 together with the medical association will some day,
21 in the not too distant future, will be able to find
22 the formula by which a serious manufacturer can get
23 information across to the doctor without this
24 tremendous wastage of everybody's materials and time
25 and money, I think this is an area for the industry
26 and for the medical profession to arrive at some
27 solution or to get closer to a rational approach to
28 this.

29 THE CHAIRMAN: Are there any others here
30 who would like to ask some questions of Mr. Antoft?



1 MR. McLEOD: Just to clear up one point
2 which arises out of Mr. Frawley's questions. You said
3 some of your products must be sold on prescription and
4 some don't require prescriptions. Do you regard that
5 second class of drug store as ethical drugs?

6 MR. ANTTOFT: Yes, because none of our
7 products are advertised directly to the public. The
8 Canadian Food and Drug Regulations has only a very
9 limited list of drugs that require a prescription.
10 These are the ones that are subject to obvious abuse.
11 For example some years ago the Canadian Food and
12 Drug Administration removed without any prior notice
13 to us, which, of course, didn't matter one way or the
14 other, but we were surprised when ACTH was removed
15 from the prescription list or removed from Schedule
16 F of the Act. When I inquired for the possible reason
17 for this there was a very logical explanation. We
18 were trying to simplify the administration of the Act.
19 We thought it was highly unlikely a patient would
20 administer ACTH unless he was under the care and
21 supervision of a physician so therefore this is an
22 unnecessary encumbrance on the administration and
23 not a drug which is subject to abuse.

24 MR. McLEOD: Is there a considerable number
25 of drugs that while they are not prescription drugs
26 are nevertheless considered by the industry and by
27 the profession to be ethical drugs?

28 MR. ANTTOFT: Very definitely. The majority,
29 I would say that the majority of drugs manufactured by
30 ethical drug manufacturers are not Schedule F drugs,



1 and therefore may be bought on an over the counter
2 basis.

3 MR. McLEOD: There would be a distinction
4 again between those and what are known as patent
5 and proprietary?

6 MR. ANTOFT: Because patent and proprietry
7 medicines are the ones that are advertised to the
8 public in the form of newspaper advertising and
9 magazines or television and so on.

10 MR. McLEOD: There has recently been a
11 revision in the laws on controlled drugs and requiring
12 licensing and so on. Have those new laws and
13 requirements come into effect yet or are they some
14 months away?

15 MR. ANTOFT: I believe they came into effect
16 this month, or rather last month. They control the
17 barbituates and anphetamines, the so-called goofballs.
18 These, of course, have always been prescription
19 drugs. It is just the control on these have been
20 tightened up tighter than the ordinary regulations
21 required. The doctors prescription and so on weren't
22 always being followed. There were quantities of
23 these substances that were getting out into the hands
24 of certain sections of the public without having gone
25 through this procedure of prescription, so the new
26 regulations were merely to put teeth into what has
27 always been the legislative intention with regard
28 to these substances.

29 MR. McLEOD: Is your firm a member of the
30 Canadian Pharmaceutical Association?



1 MR. ANTOFT: No, we are not.

2 MR. MacLEOD: Were you invited to join that
3 association?

4 MR. ANTOFT: Yes, we were.

5 MR. McLEOD: What was your reason for not
6 joining?

7 MR. ANTOFT: I think the reason at the time
8 we didn't join, we had applied for membership and
9 at the time the cost of membership was quite reasonable
10 but the same year that we were accepted the membership
11 fee went up some 200 per cent and we felt at the time
12 the expenditure was not justified.

13 MR. HUME: All these inquiries put the fees
14 up, Mr. Chairman.

15 MR. FRAWLEY: They will go up after they
16 get your bill.

17 MR. McLEOD: Is it fair that
18 the membership fee in the Canadian Pharmaceutical
19 Manufacturers Association would represent a serious
20 cost to a firm of your size?

21 MR. ANTOFT: At that time we were operating
22 very close, probably making a loss that year. It was,
23 I think, a matter of \$500.00 and this loomed large
24 at the time.

25 MR. McLEOD: Could you express any opinion
26 as to whether or not the membership fee of the Canadian
27 Pharmaceutical Manufacturers Association may keep
28 other small firms out of membership?

29 MR. ANTOFT: I would think it is quite likely,
30 yes.



1 THE CHAIRMAN: Do you know of any such?

2 MR. ANTOST: No, I have no direct knowledge,
3 but I would -- I was asked an opinion.

4 MR. McLEOD: Now, in opening your remarks
5 you made this statement, I think that your company
6 operates in a way that is not too common in Canada.
7 Just what did you mean by that?

8 MR. ANTOST: I meant to say we were -- as
9 was implied by the findings here that small companies
10 wouldn't engage in manufacturing new and original
11 products and that they weren't doing any research and
12 so on, so I pointed out, as a preface,
13 perhaps we were an exception. We were certainly
14 in respect to the data on which this particular
15 statement was based.

16 MR. McLEOD: Do you consider that the
17 statement which you have quoted from, that statement
18 applies to a number of small firms in Canada?

19 MR. ANTOST: I think there are firms to
20 which the statement applies, but I think that is too
21 general to be permitted to stay in a categorical way.

22 MR. McLEOD: Put in too sweeping a form?

23 MR. ANTOST: Yes.

24 MR. McLEOD: Do you find in your experience
25 that there was any trouble having your products accepted
26 because you were a small firm?

27 MR. ANTOST: I think, yes, that we did suffer
28 from that as a handicap during our first few years,
29 yes.

30 THE CHAIRMAN: That is not a handicap now?



1 MR. ANTOfT: No.

2 MR. McLEOD: So at one time, at least, the
3 statement was true, that your products weren't accepted
4 simply because you were a small firm and didn't have
5 the same name throughout the industry as large firms
6 did?

7 MR. ANTOfT: Yes.

8 THE CHAIRMAN: Is it because you were small
9 or because you were a new firm?

10 MR. ANTOfT: I think newness is the key word
11 there.

12 MR. McLEOD: How did you happen to get into
13 this particular field, cortisone or ACTH field?

14 MR. ANTOfT: Well, the history of my company
15 is based on a close friendship with some of the
16 principals of a Danish pharmaceutical house who
17 at that time were starting to manufacture ACTH. With
18 a worldwide shortage of pituitary glands they were
19 interested in seeing if it could be possible to gather
20 pituitary glands in Canada. I agreed to look into
21 the matter. I found very soon that there was an
22 export ban in Canada of these pituitary glands because
23 it was felt that they were necessary in our own
24 manufacture, Canadians own manufacture of ACTH. A
25 series of events followed through which we set up
26 a manufacturing plant here. The original intention
27 was that the Danish company was to share in the
28 financing of the Canadian company. However, they
29 were unable to do this because of their currency
30 restrictions and we came into being and grew as a



1 wholly Canadian company.

2 MR. McLEOD: The question I wanted to explore
3 with you was whether or not it wasn't the association
4 with the Danish company or companies which you spoke
5 of which enabled you to get started in this field?
6 In other words could a small company starting in
7 Canada without the advantage which your company
8 apparently possessed, be able to accomplish the same
9 thing in this field?

10 MR. ANTOFT: I don't think you can make
11 a generalization on a particular case. There is the
12 case of a company in Montreal, Lachine. I don't know
13 too much about their history. I know they are
14 entirely a Canadian company. They have been growing
15 in the last few -- last ten, fifteen years since I
16 have been interested in the pharmaceutical industry.
17 I think in some ways that this demonstrates that
18 a Canadian company, if it is able to have original
19 ideas and are willing to take chances, can grow.

20 MR. McLEOD: Has this company you have been
21 speaking of developed some new products?

22 MR. ANTOFT: I think they have developed
23 new methods of making old products. I am not too
24 familiar with them, but I also think some of our
25 basic Canadian companies are a good demonstration of
26 organization that started in a small way, the
27 different companies like Horner and Frosst. Ayers,
28 was started as a Canadian company and of course has
29 grown.

30 MR. McLEOD: Yes, I was just exploring this



1 aspect with you, your company, apparently has
2 accomplished a great deal in the field of research
3 and it is a very small company, but you have spoken
4 of association with certain companies in Europe. I
5 am wondering if that was the key factor in enabling
6 you to accomplish the things which you have?

- AG/bg 7 MR. ANTOFT: Oh yes. I think that this has
8 contributed greatly to our own particular success, yes.

9 MR. McLEOD: Are any of the drugs you work
10 with patented?

11 MR. ANTOFT: Yes.

12 MR. McLEOD: Do you hold any patents on them?

13 MR. ANTOFT: We hold some patents, not on
14 drugs we are currently producing, but there are
15 patents in existence. We pay a royalty to the owner
16 of certain products that we make, because we happen
17 to get into a field that this manufacturer's process
18 was a necessity.

19 THE CHAIRMAN: You are a licensee?

20 MR. ANTOFT: We are a licensee in this case,
21 yes.

22 MR. McLEOD: Did you have any difficulty
23 in obtaining licenses on a patent which you wanted to
24 take advantage of?

25 MR. ANTOFT: No, we never had occasion that
26 we had to seek patent rights that were hard to get.
27 In a few instances that we operated under license we
28 certainly had no difficulty in procuring such licenses.

29 MR. McLEOD: Do you know if licenses under
30 those patents are normally granted generally, can



1 almost any company get the type of license that you
2 secured?

3 MR. ANTIFT: I think in one instance that the
4 company was very concerned that we should be qualified
5 to put out a product that was not going to give a black
6 name to the particular preparation. In the other
7 case, I cannot say whether other people would be granted
8 a license readily or not.

9 THE CHAIRMAN: You obtained it voluntarily, not
10 compulsorily?

11 MR. ANTIFT: Yes, voluntarily.

12 MR. McLEOD: Do you license anybody under
13 your patents?

14 MR. ANTIFT: If we had any operative patents
15 that other people wish to use, yes we would, I think we
16 would.

17 MR. McLEOD: But, as I understand, the
18 situation has not yet arisen?

19 MR. ANTIFT: Well, the circumstances haven't
20 arisen where anybody has been interested ---

21 MR. McLEOD: Do you sell your products under
22 trade names?

23 MR. ANTIFT: Yes, generally. We do have some
24 simple substances that we sell under their so-called
25 generic names.

26 MR. McLEOD: What factors do you take into
27 consideration when determining whether you will sell
28 under the trade name or under the generic name?

29 MR. ANTIFT: Our Duracton, which has been
30 mentioned, this is corticotropin with carboxymethylcellulose,



1 and it is obvious there why should we use a trade name.
2 We still list on the label that it is the corticotropin
3 with carboxymethylcellulose, although we would prefer
4 to call it ACTH with CMC, which would simplify things,
5 but the Canadian Food and Drug Regulations require
6 us to call it corticotropin with carboxymethylcellulose.

7 MR. McLEOD: The name you have given would
8 be the chemical name?

9 MR. ANTOFT: Yes, it describes the composition.

10 MR. McLEOD: That is not what is commonly
11 known as a generic name?

12 MR. ANTOFT: Yes it is.

13 MR. McLEOD: The same sense as chloropentathol?

14 MR. ANTOFT: Yes, in the same sense.

15 MR. McLEOD: What would be the chemical name
16 for the one you have just given me as a generic name?

17 MR. ANTOFT: Of course, corticotropin is
18 a hormone which is not yet characterised. Yes, it
19 would of course have a structural name once the
20 arrangement of the various peptide changes in the
21 molecules is completely verified.

22 MR. McLEOD: The point is that the illustration
23 that you have given, you use a trade name because it
24 is simpler than a generic or chemical name?

25 MR. ANTOFT: That is right.

26 MR. McLEOD: Are there any other reasons which
27 would influence you?

28 MR. ANTOFT: Well, of course also the name
29 Duracton, because it is a unique substance. It has
30 certain characteristics that are not shared by other



1 forms of ACTH, which makes it readily identifiable
2 by a physician as being a substance that has certain
3 activities that he associates with the name.

4 MR. McLEOD: In this instance there would
5 be no question of going and buying the same product
6 under its generic name, because it would not be on the
7 market?

8 MR. ANTOFT: Yes, it just does not exist.
9 This is a case, I think I can say very safely that
10 this is the case with all our products that are sold
11 under trade names, that is that there is no
12 corresponding generic name for these particular
13 products.

14 MR. McLEOD: Let us go to the reverse case,
15 the products which you sell under generic names. What
16 would influence you to adopt that policy?

17 MR. ANTOFT: For example, we sell potassium
18 chloride tablets, which are a very simple and
19 uncomplicated type of medication. It would be
20 presumptuous to give this a trade name, and try to
21 pass it off as other than potassium chloride.

22 MR. McLEOD: In your case, do your products
23 fall into two extremes, on the one hand unique, and
24 on the other hand common?

25 MR. ANTOFT: No, not necessarily. I think
26 there are many graduations in between. We for example
27 sell a straight ACTH, without any admixture, which
28 we sell under a trade name, Corticotropin-Nordic, which
29 indicates the manufacturer.

30 MR. McLEOD: Are there other brands of ACTH



1 on the market that are sold under trade names?

2 MR. ANTOST: Yes, there are several others.

3 MR. McLEOD: So that a doctor prescribing
4 ACTH has the choice of prescribing that drug under the
5 brand name of other manufacturers, or under generic
6 name, in which case your product at least will be
7 available?

8 MR. ANTOST: Yes, that is correct. He would,
9 if he prescribed corticotropin, he would be getting
10 a short-acting preparation which is useful, but whose
11 usefulness is somewhat limited. If he prescribes any
12 of the long-acting types of preparations, then he
13 is trying to define the type of activity which he
14 expects from this particular drug which he is prescribing.

15 MR. McLEOD: If your ACTH were supplied under
16 its generic name, do you think it would be as good as
17 any products that could be obtained under a brand name?

18 MR. ANTOST: Yes, well, I think that the
19 manufacturer's name, his facilities for the manufacture,
20 control, and so on, are the important things, not the
21 trade name or the amount of advertising or any of these
22 things.

23 MR. McLEOD: Yes, but I am just trying to
24 pin you down to this particular case, where you have a
25 product on the market under its generic name, other
26 manufacturers have an equivalent product under trade
27 names, and I am asking you if in your opinion your
28 generic name for it is as good as any on the market
29 under a trade name?

30 MR. ANTOST: Oh, yes, very definitely.



1 MR. McLEOD: I think you mentioned in your
2 brief that you were doing the preparation of certain
3 injectibles for another firm?

4 MR. ANTOfT: Yes, that is correct.

5 MR. McLEOD: And the bulk material comes in
6 from the United States?

7 MR. ANTOfT: That is correct.

8 MR. McLEOD: And you have facilities for
9 preparing these products for the market?

10 MR. ANTOfT: Yes, that is correct.

11 MR. McLEOD: Why wouldn't you get into the
12 business of manufacturing those, and selling them
13 under your own label?

14 MR. ANTOfT: Because this field of antibiotics
15 manufacture of the bulk material is a very highly
16 complex and specialized field, in which we are neither
17 experienced nor equipped. We specialize in the field
18 of pituitary hormones and the field of the other
19 hormone substances in which we are specialists.

20 MR. McLEOD: Couldn't you buy the bulk products
21 in the same way in which they are shipped into you now?

22 MR. ANTOfT: Possibly, I have never tried.

23 MR. McLEOD: You have never explored that
24 aspect?

25 MR. ANTOfT: No.

26 MR. McLEOD: I was just wondering why, if
27 these products were available on the market and
28 you evidently have the facilities for preparing these
29 products, why you do not go into it on your own?

30 MR. ANTOfT: Well, also in the field of selling



1 these. This is a completely different group of
2 doctors and purchasing personnel to deal with, and
3 we don't have the sales force to concentrate on this
4 particular area, so we confine ourselves to the field
5 in which we are experienced, and in which our sales
6 people know how to deal with the medical profession
7 and the group of the medical profession that we
8 appeal to is only a fairly small segment of the whole.

9 MR. McLEOD: Just jumping to something
10 completely different for a moment. I was going to
11 ask you, there appears to be some suggestion in the
12 United States that manufacturers' list prices in so
13 far as prescription drugs are concerned, be abolished,
14 done away with, and not used. Has it come under
15 your notice that anything like that has been
16 discussed in Canada?

17 MR. ANTTOFT: No, I don't recall any discussions
18 along those lines. I think that in our own case our
19 list price is merely a convenience. We don't intend
20 this to be the price at which the drug is sold. It
21 is purely a base from which to figure discounts, rather
22 than to publish a separate price list for wholesale
23 and a separate price list for druggists and hospitals
24 and so on, we publish one price list, and then we
25 tell the various areas what their discount is.

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1 MR. McLEOD: Yes. Have you heard anything
2 about this movement in the States?

3 MR. ANTORT: No, I haven't. I know that
4 the Federal Trade Commission is exploring the whole
5 area of pricing, but I haven't heard any proposals to
6 outlaw so-called price lists.

7 MR. McLEOD: You had some discussion with
8 Mr. Whiteley, Commissioner Whiteley, in relation to
9 the figures set out in your brief about cost
10 prescriptions in Denmark and comparative I think, were
11 \$1.00 and \$2.78. If my calculations are correct,
12 if we assume that the Canadian druggists charge 50
13 per cent prescription fee, his basic cost would still
14 be \$1.36.8 -- call it \$1.37. If he charges the
15 75 cent prescription fee his basic cost is approximately
16 \$1.22, so that the price which the buyer in Canada
17 faces is considerably higher than the consumer pays
18 in Denmark. It would appear to follow.

19 MR. ANTORT: Yes, but also as I explained
20 there is the other factor that the range of medicine
21 that is prescribed is possibly different, vastly
22 different in Denmark.

23 MR. McLEOD: That was my point. I suggest
24 your comparison with -- it was not suggested where as
25 shown in the statement identical prices are taken, take
26 chlorpromazine.

27 MR. ANTORT: No, I see what you are driving at.
28 I didn't intend my remarks to reflect a specific
29 examples given out. I was merely pointing out that
30 the whole retail field is organized in an entirely



1 way and for this reason you have to make some research
2 when you start trying to compare directly the prices
3 of the medication in one country and the other.

4 MR. McLEOD: Yes. My friend, Mr. Hume,
5 asked you if you thought that it was a business
6 decision that 35 per cent was necessary as an expenditure
7 for promotion. Did you say in your statement you
8 regarded your promotional activities as rather modest,
9 you try to steer a middle course?

10 MR. ANTFOOT: Yes, I think in view of the
11 fact that our volume is not very great our total
12 expenditure dollar-wise does not loom very large, but
13 percentagewise, of course, it is 35 per cent of our
14 expenditures. It is not a business decision that
15 we spend 35 per cent. It is the effect, something
16 like Topsy. It started off with no expenditure and
17 we gradually worked up to the point where we were
18 starting to get an increase in volume that justified
19 further increases in our selling expenses. It is
20 only that after examining the situation we find that
21 statistically it amounted to 35 per cent.

22 MR. McLEOD: You feel that the expenditure
23 is necessary under the present circumstances?

24 MR. ANTFOOT: Yes, unfortunately.

25 MR. McLEOD: Do you think you could increase
26 your sales significantly by putting more money into
27 advertising?

28 MR. ANTFOOT: Yes, I think if we put more
29 money into advertising, if we had more money to put
30 into advertising -- there is always a time lag --



1 that we would recover this money in probably about
2 the same proportion. In other words, we spend 35 cents
3 additional and we would have \$1.00 additional in sales.

4 MR. McLEOD: It is evidently your opinion
5 that advertising is quite effective in this field?

6 MR. ANTOFT: Yes, there is some signs lately,
7 particularly since this brief was prepared, that the
8 value of direct mail advertising may be declining,
9 but this, of course, is too short a period to really
10 tell.

11 MR. McLEOD: In your opinion as the man
12 in the industry has this power been used, has money
13 been spent on advertising products where, in your
14 opinion, it shouldn't have been spent or as much have
15 been spent on the particular product?

16 MR. ANTOFT: Yes, I usually -- our medical
17 consultant periodically delivers up to us samples of
18 his mail for a week or so. I would say there is a
19 great deal of it is just trivial in the type of
20 thing it is trying to promote. I would say that
21 manufacturers must continually, that is, manufacturers
22 who were interested in trying to do something about
23 this situation must continually check the activities
24 of the advertising department to see they don't run
25 away with themselves and misuse the power of the
26 printed word.

27 MR. McLEOD: You told either the Chairman
28 or one of the Commissioners that the nine per cent for
29 quality control, research and development was subject
30 to an upward adjustment, that figure might not be



1 precisely right for reasons you enumerated. Now,
2 could you possibly have done the work which your firm
3 has obviously done if you hadn't had the connections
4 you mentioned previously?

5 MR. ANTTOFT: Oh yes, for example, the human
6 growth hormones project, the various pituitary functions
7 -- they had nothing whatsoever to do with our research
8 connections overseas. They are all independent
9 Canadian investigations. There are times when we
10 agree with our Swedish plant that one of us has
11 developed an idea, a nucleus of an idea and we agree
12 that one of us will try to pursue one direction and
13 another will pursue another direction. We have
14 such a project currently under investigation where we
15 have a bacteriologist who is particularly interested
16 in the field in which he is well qualified to work
17 and the Swedish people have some connections in the
18 veterinary field where this substance might have
19 application. Here we are working along parallel lines
20 with the same subject. This is what I mean by
21 research pool.

22 MR. McLEOD: Do I take it from your brief
23 you are convinced size has no direct relationship to
24 achievement in the field of research?

25 MR. ANTTOFT: Yes.

26 MR. McLEOD: That a small company may make
27 as important contributions as a big company?

28 THE CHAIRMAN: A company of your size would
29 hardly be able to engage in one particular research
30 project that would cost a million or two million dollars?



1 MR. ANTOFT: No, within the limitations imposed
2 on us by our size. Just because you are small does
3 not mean you have to stop and say I am going to
4 sell the stuff the other fellow develops.

5 MR. McLEOD: Do you have any trouble with
6 other firms pirating your discoveries?

7 MR. ANTOFT: Not seriously. We have on
8 occasion, but not with people -- no.

9 MR. McLEOD: Have you ever felt that other
10 firms have unfairly taken advantage of your work in
11 the field by putting out products that you were
12 largely responsible for?

13 MR. ANTOFT: No, I don't think we feel --
14 no, we don't feel this way in any instance.

15 MR. McLEOD: Do any of the so-called generic
16 name houses sell products equivalent to yours?

17 MR. ANTOFT: Yes -- at the moment it so happens
18 we have a rather embarrassing situation with the
19 company that has borrowed our corporate name. We
20 feel that this may be -- well, I wouldn't impute
21 motives to them, but certainly I don't think they would
22 do this if they thought it was doing them any harm
23 to be known by the name of Nordic.

24 MR. McLEOD: I think you have already answered
25 the main point I was making. I was inquiring about
26 whether you have found your discoveries, the benefit
27 of your discoveries being syphoned off by other
28 firms rushing in?

29 MR. ANTOFT: No, I don't think that has
30 happened.



1 MR. McLEOD: I think that is all I have, sir.

2 THE CHAIRMAN: Any other questions?

3 MR. HUME: There is one question arising
4 out of Mr. McLeod's. When you sell this drug Mr.
5 McLeod put to you under your generic name is your
6 company name associated with this so the doctor or
7 whoever is prescribing it knows who made it?

8 MR. ANTIFT: Yes, we attempt to have the
9 name associated.

10 MR. FRAWLEY: Following that, if the
11 doctor prescribes this corticotropin carboxymethyl-
12 cellulose on the prescription and I went to the
13 drug store I would get Duracton.

14 MR. ANTIFT: That is correct.

15 MR. FRAWLEY: I wouldn't be helped a bit
16 price-wise?

17 MR. ANTIFT: That is right.

18 THE CHAIRMAN: If that is the only product
19 which has those ingredients, it is the only one you
20 could get.

21 There are no further questions, thank you,
22 Mr. Antoft. Thank you for giving us the benefit
23 of your experience.

24 I would make one comment. There have been
25 no representations as yet from the French speaking
26 groups in Canada. I think that may be due to the
27 fact the Translation Bureau at Ottawa has been so
28 terribly busy they have only just completed translating
29 the Director's volume of material into French. It
30 will be available for French speaking groups if they



1 wish to make representations to us. We will not
2 close off the hearing finally until they have had
3 an opportunity to decide, after looking at the
4 documents in French, whether they wish to make any
5 representations to us. We had some intimations from the
6 College of Pharmacists in the Province of Quebec that
7 they might be making representations to us, but
8 they are not here today. It may be because they were
9 waiting for the French version of the Director's
10 Volume. As a matter of fact we had several requests
11 for this volume in French. We hope very shortly
12 to deliver it to those who have asked.

13 Are there any others here today who would
14 like to make representations to us? We had no others
15 when we opened this morning.

16 There are some factors in the whole picture
17 which we hope some of the companies might be able
18 to assist us on, in getting a clearer picture. We
19 had hoped some of them would indicate the reasons
20 why they didn't seek compulsory licenses. We would
21 like to have that picture as clear as possible, our
22 law being different from that of the United States.
23 We would also like to have further expressions than
24 we have had from Mr. Antoft as to the belief of the
25 manufacturers concerning the value and the necessity
26 for what seems like a pretty large expenditure in
27 promotion and advertising. These things do enter
28 into the total cost. We would like to have some
29 further information along those lines. If we are
30 not to have it here in Montreal possibly we could



1 get some information along that line when we proceed
2 to Toronto.

3 If there are no others who wish to make
4 representations now during the session in Montreal
5 this would seem to be the close of the Montreal
6 sitting.

7 MR. HUME: Perhaps I could assist on this
8 matter of promotional literature. In the brief that
9 is now in the course of preparation and which will
10 be presented in Toronto, rather extensive attention
11 is paid to the matter of promotional literature and
12 a considerable volume of examples selected at random
13 will be presented.

14 THE CHAIRMAN: Your position, Mr. Hume, is
15 you are speaking for the Association as a whole and
16 not for any of the individual manufacturers?

17 MR. HUME: I don't act for any of the
18 manufacturers.

19 THE CHAIRMAN: I thought we might get some
20 more detailed information as to the particular
21 reasons that have effected some of the manufacturers.
22 If they feel it is not desirable to make these
23 representations we will have to get along without
24 them.

25 The hearing will be adjourned.

26 ---Whereupon the hearing adjourned to Toronto, October
27 16th, 1961 at 10:00 a.m.

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Toronto, Ontario,
October 16th, 1961.

--- On commencing at 10.05 a.m.

THE CHAIRMAN: Now, ladies and gentlemen, as you all know this is a hearing of the Restrictive Trade Practices Commission, an inquiry relating to the manufacture, distribution and sale of drugs. I think most of you will know we have had hearings in a number of cities across Canada. This is likely to be the concluding series of hearings although it is possible that we may have one subsequently if it appears necessary.

To begin with this morning, we would like to have the names of all those who are appearing, either making representations on their own behalf or on behalf of some organization or client.

MR. IAN WAHN: Ian Wahn. I have with me Ivan Thornley Hall. We represent Cyanamid of Canada Limited, and hope to give evidence this morning from the company. We have with us its President, Mr. B.F. Bowman, and also Dr. R.G. Warminton, the Medical Director of Medical Products Department. Also Mr. Ralph B. Thompson, the manager of the Medical Products Department, who will give evidence on behalf of the company.

MR. H.E. COOK, Q.C.: H.E. Cook, Mr. Chairman. I am representing the Canadian Pharmaceutical Association. With me today is Mr. John Turnbull, who is Secretary-Manager of that Association. Later in this hearing we expect to attend with other officers, but there are only two of us this morning.

THE CHAIRMAN: Are you an officer?



1 MR. COOK: I am counsel for the Association.

2 THE CHAIRMAN: Should I put "Q.C."?

3 MR. COOK: You may.

4 MR. F.R. HUME, Q.C.: Mr. Chairman and
5 gentlemen, F.R. Hume, representing the Canadian Pharmaceu-
6 tical Manufacturers' Association.

7 MR. E.A. McNAB: E.A. McNab, President of
8 the Canadian Society of Hospital Pharmacists.

9 MR. J.J. FRAWLEY, Q.C.: J.J. Frawley,
10 representing the Province of Alberta.

11 MR. G. McCracken: Mr. Chairman, George
12 McCracken, representing the Canadian Hospitals Association.
13 With me is Mr. John Hazlehurst.

14 THE CHAIRMAN: Any others? Mr. MacLeod,
15 are you on your own?

16 MR. F.M. MACLEOD: F.M. MacLeod.

17 THE CHAIRMAN: Before we begin hearing any
18 briefs, perhaps we would like to know, because it may suit
19 the convenience of some of those who are here, how long
20 they expect to stay, and if it is extremely inconvenient
21 to appear at any particular time. We have arranged that
22 the Cyanamid Company would be allowed today or most of
23 today at any rate as they have brought people here from
24 Montreal, and it is rather awkward to keep them for any
25 great length of time.

26 Are there any here who feel they must appear
27 today or tomorrow or at any particular time? I should also
28 mention for the Manufacturers' Association, a tentative
29 arrangement, they will start Wednesday morning, but there
30 may be an hour or two variation in the time we actually



1 get going depending on what we are doing on Tuesday night.
2 Are there any others who have any particular time they
3 must appear?

4 We had one or two other briefs I might say
5 from organizations who have not indicated their presence
6 this morning. Perhaps they will be appearing.

7 MR. HUME: May I interpret your remarks to
8 indicate the Manufacturers' Association in any event would
9 not be going on before Wednesday morning? I understand we
10 may be delayed later on Wednesday, but would we be likely
11 to be called Tuesday afternoon?

12 THE CHAIRMAN: It would depend on what
13 develops today. I was under the impression the Cyanamid
14 Company might easily take the whole day, depending on how
15 much questioning arises out of the brief.

16 MR. HUME: Perhaps I can arrange with Mr.
17 Frawley to make sure that would be so.

18 THE CHAIRMAN: You would like to appear on
19 Wednesday?

20 MR. HUME: Yes.

21 THE CHAIRMAN: That is what I understood.

22 MR. HUME: There are some people coming in.
23 I was not going to get them here before Wednesday unless it
24 was necessary.

25 THE CHAIRMAN: I think you can depend on that.

26 MR. HUME: Thank you.

27 THE CHAIRMAN: If there are no people who
28 wish to make any special representations, we will ask Mr.
29 Wahn - you will be speaking yourself? - to present the case
30 for Cyanamid Company.



1 MR. WAHN: Mr. Chairman, I would ask Mr.
2 Thompson to take the stand, please. Mr. Chairman, members
3 of the Commission, we have prepared a brief outlining the
4 views of the company, and if it is the pleasure of the
5 Commission, perhaps Mr. Thompson could present the brief
6 on behalf of Cyanamid of Canada.

7 THE CHAIRMAN: I think Mr. Thompson might
8 read it because we have not seen it or had time to study it,
9 and make any comment that you feel desirable as you go
10 along. There may be questions that arise as you go along.

11 MR. THOMPSON: I would be happy to be inter-
12 rupted if that should be the case.

13

14 SUBMISSION OF CYANAMID OF CANADA LIMITED

15 MR. THOMPSON: Mr. Chairman: My name is
16 Ralph B. Thompson. I represent Cyanamid of Canada Limited,
17 of which I am Manager of the Medical Products Department
18 (formerly known as the Lederle Laboratories Division).

19 THE CHAIRMAN: How are the acoustics? Can
20 people hear?

21 THE AUDIENCE: No.

22 MR. THOMPSON: I am a citizen of Canada by
23 birth, and a graduate of the University of Toronto in
24 Applied Science. We are pleased to be able to appear before
25 this Commission today and to present our comments on the
26 situation regarding drugs and drug prices in Canada; also,
27 to comment on some of the conclusions of the Director of
28 Investigation and Research in his Statement of Material to
29 this Commission.

30 Since the end of World War II, there have



1 appeared on the markets of the world several drugs which
2 have gone under the name of "wonder drugs": antibiotics,
3 steroids and tranquilizers. These discoveries have consti-
4 tuted major breakthroughs in the treatment of hitherto
5 frequently fatal and often incurable diseases. These drugs
6 were without exception expensive to develop, to produce, and
7 to market. This was generally accepted as a fact and
8 scarcely caused surprise. All these products have dropped
9 in price, and none have risen in price, over a period of less
10 than 15 years. What is surprising is that their prices have
11 not in fact risen, as has the price of practically every
12 other consumer item in the past 20 years.

13 THE CHAIRMAN: Just on that point, Mr. Thomp-
14 son, is it necessarily surprising that they have not risen
15 because we have been under the impression from what the
16 Director said and what some other people have told us
17 that the initial cost of the new drugs is very high, but
18 after they have been produced in quantity, the actual cost
19 of production does go down; therefore the price might go
20 down rather than go up.

21 MR. THOMPSON: Well, there are two forces
22 at work. There is the downward tendency as the technology
23 improves - manufacturing technology improves. There is the
24 underlying upward pressure as costs due to normal costs of
25 doing business have risen, and sometimes one will prevail
26 and sometimes the other will prevail.

27 THE CHAIRMAN: Then there is also the matter
28 of the initial cost of the initial research, which I would
29 imagine the companies have tried to write off within a
30 certain period?



1 MR. THOMPSON: Yes. I hope to comment on
2 that a little later. It is a difficult decision for a
3 manufacturer to make as to over what period of time to
4 seek to write off his research investment. He has to
5 estimate the length of time the drug will be popular.

6 THE CHAIRMAN: Yes, but I was thinking when
7 that was written off the effect of that would probably be
8 to lower the cost.

9 MR. THOMPSON: Yes, indeed.

10 THE CHAIRMAN: Lower the price.

11 MR. THOMPSON: I think that effect will be
12 seen as I talk about the antibiotic.

13 Yet within only the last two or three years
14 there has been an anguished public outcry over North
15 America that the cost of medication is enormously high.
16 The cry has been taken up by politicians in both Canada and
17 the United States, and characterized as an expression of
18 popular discontent. The price of drugs has been made a
19 vehicle for protestation by well-meaning but often misin-
20 formed individuals whose complaints would be more properly
21 directed at the high cost of living itself. An element of
22 hysteria has been introduced. A prominent member of the
23 Canadian Parliament announced that the price of drugs was
24 "extortionate". We question whether the speaker had the
25 remotest idea whereof he spoke, or, if he gave a second
26 thought to what he said, whether he might not have
27 complained that the cost of living itself was extortionate.
28 We are aware that this Commission is not
29 simply constituted for the purpose of deciding whether
30 indeed the costs of drugs are too high, but rather to



1 determine whether the letter or indeed the spirit of the
2 Canadian Combines Legislation has been violated.

3 THE CHAIRMAN: As a matter of fact, Mr.
4 Thompson, we are not in this inquiry directly concerned
5 with whether the letter has been violated. There is no
6 allegation of offences, but you mentioned "spirit". That
7 may be perhaps closer to what we had in mind.

8 MR. THOMPSON: We are also aware that the
9 conclusions of the Director in his Statement - I refer to
10 what has been called the Green Book. When I use the expres-
11 sion "Green Book" I think that will be satisfactory.

12 THE CHAIRMAN: I think by now we understand
13 both.

14 MR. THOMPSON: We are also aware that the
15 conclusions of the Director in his Statement, while they
16 are to the effect that drug prices are high, do not express
17 an opinion as to the rightness or wrongness of these
18 prices. On page 237, the Director says - "In the light of
19 present costs of production and the resources required in
20 the industry, present prices may or may not be reasonable".

21 We come to this Commission with no apologies
22 to make for our business practices. We are a commercial
23 enterprise, and we are engaged in one of the most intensely
24 competitive industries on this continent. The drug
25 industry, like any other, is made up of a cross-section of
26 people, none of whom are any less honest, less responsible
27 or less public spirited than those in any other industry;
28 indeed, we are inclined to think perhaps somewhat more so
29 than many, by reason of the industry's concern with public
30 health.



B/MR/hm

1 In 1917, before it was a part of Cyanamid,
2 the Lederle business commenced operations in Canada under
3 the name Lederle Antitoxin Laboratories, with offices in
4 Ottawa. It moved in 1918 to Montreal, and during the
5 'Twenties' the business expanded westward and eastward to
6 the Maritimes.

7 Lederle has consistently played a prominent
8 role in the field of public health in Canada and the U.S.
9 As the name implies, Lederle Antitoxin Laboratories had
10 as its main business biological and bacterial products.
11 It had the reputation in North America of being the fore-
12 most in its line of antitoxins, vaccines, toxoids and
13 sera. In 1917 and 1918, when the influenza epidemic was
14 raging in Canada and the U.S., Lederle influenza-combined
15 vaccine and pneumococcus-combined vaccine were supplied to
16 emergency hospitals. In 1927, during the severe typhoid
17 epidemic in Montreal, Lederle supplied large amounts of
18 typhoid-combined vaccine to the Montreal City Board of
19 Health.

20 The Lederle business was purchased by
21 American Cyanamid Company in 1930, and renamed Lederle
22 Laboratories Incorporated. The parent, American Cyanamid
23 Company, established a Canada subsidiary in 1934 known as
24 North American Cyanamid Limited, which handled its several
25 products in Canada. In 1946 the Lederle Laboratories
26 Division of this subsidiary was established, known now
27 as the Medical Products Department of Cyanamid of Canada
28 Limited, which is the present name of the Canadian company.
29 There are six Cyanamid Manufacturing plants in Canada at
30 the present time producing a wide variety of chemical and



1 other products for both animal and human use, as well as
2 for agricultural and industrial purposes. Two of these
3 plants are engaged in the production of pharmaceuticals.
4 The executive offices of the Company are in Montreal, and
5 the main manufacturing and production centre of pharma-
6 ceuticals is in the suburb, the Town of Mount Royal, Quebec.

7 Of our 1960 drug sales in Canada, 87% were
8 of products either manufactured locally from raw materials,
9 or refined locally from imported bulk chemicals. The
10 manufacture of Lederle pharmaceuticals in Canada began in
11 late 1952, made possible by the construction of a modern
12 pharmaceutical plant in Montreal. This plant was equipped
13 to carry out refining operations on crude chlortetracycline
14 (Aureomycin), and to produce a wide variety of finished
15 pharmaceutical dosage forms, such as capsules, tablets,
16 liquids and ointments.

17 In 1954 facilities were added to convert
18 bulk chlortetracycline to tetracycline (Achromycin),
19 utilizing a deschlorination process. In 1956 equipment
20 for the production of parenteral forms, that is injectable
21 forms was added to produce in Canada intravenous and
22 intramuscular dosage forms of tetracycline and a number of
23 other injectable drugs. The refining of imported crude
24 demethylchlortetracycline (Declomycin) was also carried
25 out in our Montreal plant beginning in the fall of 1959.

26 THE CHAIRMAN: Just for the record, it is
27 correct is it not that Aureomycin, Achromycin, Declomycin
28 are trade names of Cyanamid Company?

29 MR. THOMPSON: Yes.

30 At this stage, our Montreal plant was



1 refining its antibiotic requirements from imported crude
2 forms. The refined antibiotics were then used to manu-
3 facture finished dosage forms. We were at this stage
4 manufacturing antibiotic capsules, liquids, ointments and
5 other dosage forms but were not manufacturing the
6 basic drug. Here we draw a distinction between refining
7 and manufacturing as it applies to the bulk antibiotic.
8 The distinction is noted on page 169 of the Director's
9 Statement.

10 In November, 1959, manufacturing by fermenta-
11 tion of Aureomycine began at the Welland plant. This
12 enabled us to produce in Canada our requirements of animal
13 feed grade supplement Aureomycin.

14 It has recently been decided to expand our
15 antibiotic manufacturing operations at the Welland plant
16 to the point where we will manufacture completely our
17 Canadian requirements of both Aureomycin and Declomycin.
18 This expansion is scheduled to be completed by mid-1962,
19 at which time all of our human and animal requirements
20 of Aureomycin, Achromycin, and Declomycin will be manu-
21 factured in Canada through all stages from basic fermenta-
22 tion to the final dosage form. With the completion of
23 the current expansion at the Welland plant, Cyanamid's
24 Canadian investment in antibiotic production facilities
25 alone will amount to \$1,500,000.

26 Cyanamid of Canada Limited is part of a
27 world-wide organization with its parent company in the
28 United States. In common with a large segment of the
29 Canadian economy, much of the Canadian pharmaceutical
30 industry is integrated with parent companies in the U. S.



1 Cyanamid of Canada has nonetheless attained to an increa-
2 sing degree of autonomy over the years. It regards itself
3 as a Canadian operation. The Company has an independent
4 purchasing policy and has made a firm practice of
5 purchasing raw materials and supplies from Canadian sources
6 whenever possible on condition that such materials and
7 supplies meet our specifications and standards for quality,
8 and that it is economically feasible to do so.

9 Sulfamethazine Powder U.S.P. is a good
10 illustration of the application of this policy. Prior to
11 1948, Sulfamethazine Powder U.S.P. was imported from
12 American Cyanamid Company as a bulk pharmaceutical for
13 resale to the pharmaceutical industry, and finished pro-
14 ducts containing this item as an ingredient were imported
15 in finished packages for sale to retail drug accounts,
16 hospitals, etc. In 1948, we established facilities to
17 manufacture bulk Sulfadiazine, Sulfathiazole and
18 Sulfamethazine at our Welland, Ontario, plant. These
19 facilities were in operation from 1948 until 1958, and the
20 bulk Sulfamethazine Powder sold by us to other pharmaceuti-
21 cal manufacturers was produced in Welland. In 1953, the
22 construction of the manufacturing plant in Montreal enabled
23 us to begin manufacturing the finished forms of products
24 containing Sulfamethazine which had heretofore been im-
25 ported in finished form from American Cyanamid Company.

26 THE CHAIRMAN: Again for the record, the
27 initials U.S.P. stands for United States Pharmacopoeia?

28 THE WITNESS: Yes. That is a standard
29 specification of purity.

30 In 1957 it became increasingly evident that



1 acceptably uniform quality Sulfamethazine U.S.P. Powder
2 of Danish and Dutch origin could be purchased more
3 economically than we could produce it at Welland, or import
4 it from American Cyanamid. Following our standard
5 procurement policy, Sulfamethazine production was dis-
6 continued at Welland, and our requirements were purchased
7 from local agents representing Danish and Dutch manufacturers.

8 A somewhat different example is that of
9 Meprobamate, a drug used widely in the manufacture of
10 tranquilizing and anticholinergic drugs. It is one of the
11 two active ingredients of our Pathibamate Tablets.
12 Meprobamate first became available to us from American
13 Cyanamid Company, and for a period of approximately two
14 years we imported Meprobamate for use in the manufacture
15 of Pathibamate Tablets in our Montreal plant. When Fine
16 Chemicals of Canada Limited in Toronto undertook the
17 production of Meprobamate, we discontinued importation,
18 and beginning in November, 1958, we have purchased our total
19 requirements of this drug from the Canadian manufacturer.

20 Again, certain drugs are purchased in bulk
21 from our parent company in the United States for processing
22 into tablets, capsules, and other dosage forms, in our
23 Montreal plant merely because we have been unable to locate
24 a more economical source, and because the volume of our
25 requirements is not large enough to warrant production in
26 Canada.

27 MR. THOMPSON: Mr. Chairman, I would like
28 to talk about --

29 THE CHAIRMAN: One moment, I think Mr.
30 Whitely had a question that arose on page 6. When you



1 referred to Sulfamethazine Powder you spoke about buying
2 that in bulk. Now these others that you referred to lower
3 down, Pathibamate, Meproamate are those bought in bulk,
4 or refined --?

5 MR. THOMPSON: No. Our practice, up until
6 the Montreal plant was established, our practice was to
7 import tablets, finished tablets into Canada.

8 Once the Montreal plant came into operation,
9 we then moved back one stage, imported the bulk raw
10 material and made the tablets in Canada.

11 THE CHAIRMAN: Do you do the refining in
12 Canada at all?

13 MR. THOMPSON: No, not on Meproamate.

14 THE CHAIRMAN: You buy the refined ---

15 MR. THOMPSON: Bought the finished, refined
16 powder.

17 THE CHAIRMAN: And simply made the tablets?

18 MR. THOMPSON: Simply made it into tablets,
19 that is right.

20 It might be interesting to talk about
21 Canadian compared to United States drug prices Mr. Chairman.

22 -

23

24

25 -

26

27

28 -

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30



1

2 CANADIAN VS. U. S. DRUG PRICES

3 The Director's Statement (page 203) quotes
4 newspaper headlines announcing, with something approach-
5 ing alarm, that drug prices in Canada are the highest
6 in the world. If this is so, it is because the costs
7 of engaging in this industry in Canada are the highest
8 in the world.

9 The prices of most of our drugs, with the
10 exception of antibiotics, are generally higher in Canada
11 because of the effect of two factors - the 11% Federal
12 Sales Tax, which applies to virtually all pharmaceutical
13 products, prescription or otherwise; and the 15%-20%
14 ad volorem duty, applicable to virtually all imported
15 drugs as well as to many ingredients used in the manu-
16 facture of drugs.

17 To illustrate the relationship between
18 Cyanamid of Canada's prices to the retail drug trade in
19 Canada and those of our parent company in the United
20 States to the same trade class, we attach herewith a
21 percentage comparison table (Schedule A).

22 It should be noted that even though we
23 must include the 11% Federal Sales Tax, our Canadian
24 prices on all forms of the all-important broad spectrum
25 antibiotic product group were only 7.4% higher than
26 comparable prices in the United States. That shows in
27 the antibiotics product prices in Canada are 7.4% higher
28 than in the United States.

29 THE CHAIRMAN: That is an average?

30 MR. THOMPSON: Yes, that is on the basis



of comparing sales volume in total for the corresponding income for the same product in the United States at American prices.

THE CHAIRMAN: There would be variation between one antibiotic and another one? That is an average?

MR. THOMPSON: Yes, and there might be variation between dosage forms.

SCHEDULE A

COMPARISON OF CYANAMID CANADA vs. U.S. DRUG PRICES

BASED ON PRICE TO RETAILER AS OF JULY, 1960

<u>Product Group</u>	<u>% Differential Canada vs. U.S.</u>
Antibiotics	7.4
Hemantinics	10.5
Vitamins	10.5
Biologicals	18.9
Other Pharmaceuticals	20.0
Total All Human Pharmaceutical Products	11.2

Note 1 - Canadian prices used for this comparison were published prices of the Medical Products Department, Cyanamid of Canada Limited, to the retail drug trade in Canada as of July, 1960. U.S. prices were those in effect at the same time for the same products offered in the United States to the retail drug trade by Lederle Laboratories Division, American Cyanamid Company. Canadian prices include the 11% Federal Sales Tax.



1

2

THE CHAIRMAN: That is weighted average?

3

MR. THOMPSON: We took the sales of our

4

Canadian company, total sales, and then we measured, at

5

the same prices for the same product in the United States,

6

net sales incomes have been compared in the total.

7

THE CHAIRMAN: Those are not all of

8

equal weight?

9

MR. THOMPSON: No, antibiotics are

10

more permanent, for example, than vitamins.

11

THE CHAIRMAN: Excuse me, Mr. Whitely

12

has a point, whether the degree of difference in the

13

price between the Canadian and American in the antibiotics

14

is 7.4 and they run up to 18 or 20 per cent -- does that

15

reflect in any way the degree of manufacturing that is

16

done in Canada? Is the degree of difference when there

17

is more manufacture done in Canada or does that have

18

any effect?

19

MR. THOMPSON: Primarily, Mr. Chairman,

20

those prices are set for competition. We primarily have

21

corresponded to competition in setting prices. When we

22

do an increasing amount of manufacture in Canada -- normal-

23

ly when we set such prices it is increasing our ability

24

to compete.

25

THE CHAIRMAN: Where you manufacture,

26

do more of the manufacturing in Canada the difference

27

between the American prices and the Canadian prices is

28

probably less because you are able to compete more in

29

Canada?

30

MR. THOMPSON: Yes, when more of the



1
2 process is conducted in Canada, the less.

3 THE CHAIRMAN: Another question,
4 whether Cyanamid is not a leader in some of the fields
5 that start some of the competition?

6 MR. THOMPSON: I think I can give you
7 evidence that has, on occasion, been the case. We will
8 be talking about antibiotic prices a little later and
9 there is an illustration of that. Perhaps, Mr. Chairman,
10 I could clarify my answer to your question a little bit
11 by saying not all processes which increase the degree of
12 manufacturing in Canada are economically sound depending
13 upon the amount of capital required. The capital invest-
14 ment is sometimes prohibitive and sometimes the process
15 is best conducted by a highly mechanised plant which
16 cannot be practical in a market the size of the Canadian
17 market. We try to find out the situation, whether we
18 can save money by manufacturing in Canada and to install
19 facilities and automatically to improve our competitive
20 ability.

21 MR. FRAWLEY: Would you mind raising
22 your voice a bit?

23 MR. THOMPSON: I am sorry. Is there
24 anything you would like me to repeat?

25 MR. FRAWLEY: No, it is fine, but you
26 are getting into a little conversation with the Chairman.

27 THE CHAIRMAN: The room is not very
28 good from an acoustic point of view. We would like
29 people to hear so they may raise points as you go along
30 or at the end of your submission.



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You have said in view of the not too large size of the Canadian market there are some products which it is not economically feasible to produce in Canada in competition with plants which have much larger markets in other countries?

MR. THOMPSON: Yes.

THE CHAIRMAN: Which means when you say you meet competition you must be able to compete and your margin of profit will tend to go down?

MR. THOMPSON: Indeed, we have to be able to meet competition or go out of business. Wherever we can improve our competitive position by manufacturing in Canada we like to do so.

MR. WHITELEY: In the field of vitamin products, isn't that one in which there are a large number of products?

MR. THOMPSON: Oh, yes.

MR. WHITELEY: I notice the differential there is higher there than antibiotics?

MR. THOMPSON: Yes, we make a good many vitamin products. The wider variety than in the case of antibiotics and the hematinics are such that we just have to make the full range in order to compete. It isn't as simple a business as the manufacture of antibiotics once the raw material is available. Your average differential is 11.2 on sales in Canada on all products.

This is equivalent to saying that if we exclude the 11% sales tax, our Canadian prices on this



1
2 product group are actually lower than those in the
3 United States.

4 THE CHAIRMAN: Ad valorem tax?

5 MR. THOMPSON: Yes, of course, we try
6 to a void duty by manufacturing in Canada and that is the
7 purpose of our Montreal plant.

8 THE CHAIRMAN: So far as you do manu-
9 facture in Canada, the things you do manufacture in
10 Canada, the average is 11 per cent differential?

11 MR. THOMPSON: Yes.

12 THE CHAIRMAN: Your price is about the
13 same as the American plus sales tax?

14 MR. THOMPSON: Yes, plus sales tax.

15 Mr. Chairman, I think I made a mistake a
16 moment ago. I said by deducting your sales tax the
17 prices would actually be lower. That is not the case.
18 What I would like to say is that because the sales tax
19 is included in our prices, our Canadian prices on all
20 forms of the very important antibiotic group, it is only
21 7.4 per cent higher than the comparable prices in the
22 United States. On that product group if the sales tax
23 is excluded Canadian prices are actually lower. That is
24 antibiotic prices.

25 THE CHAIRMAN: You do some of the manu-
26 facture in Canada?

27 MR. THOMPSON: Yes.

28 THE CHAIRMAN: And therefore, the sales
29 tax is then totalled on the -----

30 MR. THOMPSON: The sales tax is at the



1
2 Montreal plant on our selling prices of the finished
3 packaged product.

4 THE CHAIRMAN: On those products does
5 that mean your cost of production or your margin of
6 profit, which ever it is are somewhat lower than the
7 corresponding cost in the United States?

8 MR. THOMPSON: Yes.

9 Similarly, the percentage differential on
10 hematinics and vitamins is less than the Federal Sales
11 Tax itself, not to mention the inflationary effect of
12 duty on imported ingredients, and on an overall basis,
13 the percentage differential on all our human pharmaceu-
14 tical products is 11.2% - almost exactly the amount of
15 the Federal Sales Tax.

16 Further, the degree of mechanization in
17 the production of the goods in the two countries affects
18 their comparative prices. Pharmaceuticals of all kinds
19 can be produced more cheaply in the U.S. than in Canada
20 because of the enormous degree of mechanization in
21 the U.S., itself econmically justifiable only when there
22 is a market large enough to absorb that degree of
23 mechanization. As the size of the American market is
24 increased, costs can be reduced on a progressive scale.
25 While the Canadian population is roughly ten percent of
26 the size of the U.S. population, the Canadian gross
27 national product is approximately 7% of the U.S. gross
28 national product. Where there is a greater volume, as
29 in the U.S., the manufacturer can accept a smaller return
30 on each individual sale.



1
2 The smaller size of the Canadian market
3 has the effect of increasing marketing costs. Canada
4 has two-fifths of 1% of the world's population, is one
5 of the largest countries of the world in area, and yet
6 the standard of living is among the highest in the world.
7 The cost of reaching a Canadian consumer is higher by
8 reason of the distances between small and widely
9 scattered population centres. In the U.S. there is a
10 total of 14 Lederle depots, each servicing a relatively
11 compact area. In Canada, the number of depots is only
12 six, each servicing a sales territory considerably larger
13 than its U.S. counterpart. The bulk of our sales of
14 pharmaceuticals is made on prescription through drug
15 stores. At the present time, our method of distribution
16 is based upon direct sales to retail drug stores and to
17 other outlets such as hospitals and clinic-pharmacies
18 which service prescribing physicians. Some druggists
19 still get their supplies from wholesalers. We maintain
20 warehouses and shipping offices at Vancouver, Calgary,
21 Winnipeg, Toronto, Montreal and St. John, New Brunswick.
22 It is imperative that our merchandise, including rarely
23 used but essential emergency items, be available to fill
24 prescriptions promptly, no matter where needed in Canada.
25 We believe that this method of distribution is the
26 most economical for us.

27 Furthermore, Canada is bilingual. The
28 industry relies heavily on promotional literature which
29 must be distributed in both languages.

30 The structure of drug prices is profoundly



1
2 influenced by the advertising methods of this industry,
3 shaped by legislation which restricts advertising to
4 the general public. This makes it necessary to seek
5 means of communication other than mass media, with un-
6 deniable justification, but with accompanying increase
7 in costs.

8 Furthermore, before a new drug may be
9 marketed in Canada, the Canadian Food and Drug Act
10 requires that an application in respect thereof must be
11 tendered to the Food and Drug Directorate and the data
12 approved and accepted.

13 Mr. Chairman, if I may pause, I have an
14 example of such an application. I would like to show it
15 to you. This is a new drug application.

16 THE CHAIRMAN: Is that just one appli-
17 cation or a number of copies?

18 MR. THOMPSON: That is one application.
19 It is the data on Aristocort made to the Food and Drug
20 Directorate in May, 1958. It is a steroid, a new drug
21 at that time. There are about twelve hundred pages of
22 technical data which was used by the Food and Drug
23 people in evaluating this preparation and deciding whether
24 or not it should be marketed in Canada.

25 THE CHAIRMAN: Would that be typical of
26 all applications? Would they have as large a volume
27 as that material?

28 MR. THOMPSON: Depending upon the
29 complexity of the data. They vary a good deal on the
30 thickness. This is a rather thick one. It is not the



1
2 thickest, nor is it the thinnest. I think it is a reason-
3 able representation.

4 This is an ingredient in the cost of
5 production. The material in this submission is the
6 result of a very large amount of time and effort on the
7 part of the developers of the drug.

8 Notwithstanding that similar costs for
9 raw materials and reasearch must be borne by drug
10 consumers in both countries, Cyanamid of Canada has
11 reduced the prices of many of its antibiotics to a price
12 below that prevailing in the United States. Our 11%
13 Federal Sales Tax results in these antibiotics retailing
2 14 at almost identical prices in both countries.

15 THE CHAIRMAN: I am just wondering
16 whether you have given us all the factors because you
17 pointed out with regard to some of these drugs your
18 prices are less than 11 per cent above the American
19 prices.

20 MR. THOMPSON: Yes.

21 THE CHAIRMAN: If you eliminated sales
22 tax your prices are somewhat lower than the American
23 prices?

24 MR. THOMPSON: That is true.

25 THE CHAIRMAN: You have given us quite
26 a lot of matters in which the Canadian costs are
27 substantially higher than in the United States, mechan-
28 ization, and the large market in the United States to
29 tend to reduce the costs. The size of the Canadian
30 market in sales together with a very large area -- that



1
2 is another one in which Canadian costs appear to be
3 higher. The bilingual nature of the country has the same
4 effect and perhaps the mass media -- not mass media,
5 the promotional methods to the population would be
6 larger. You get a rather uneasy feeling your profits
7 would be very low if you absorb all the costs and still
8 sell at lower prices than in the United States. Are
9 there factors in which the Canadian costs are lower?

10 MR. THOMPSON: I think, Mr. Chairman,
11 our profits are surprisingly low. If you are not aware
12 of the profit levels, I would be glad to furnish them
13 to the Commission in confidence. A manufacturer in our
14 position has to choose between staying in business or
15 not. To stay in business he must compete. There is a
16 considerable amount of gross competition between drugs
17 that have very different names. For example the
18 Tetracycline antibiotics have to compete with penicillin.
19 They have to compete with Chloramphenicol, which is a
20 different type of antibiotic. In setting prices we have
21 to have regard for these competing products, so that,
22 in fact, our prices to a large extent are set by
23 competition.
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JW/hm 1 Indeed it is often necessary to accept an extremely
2 modest net profit in order to stay in business.

3 THE CHAIRMAN: I was wondering if there
4 were any factors in your cost of production, for instance,
5 if your wages are lower in the United States. What about
6 wages and salaries?

7 MR. THOMPSON: They are somewhat lower in
8 Canada. Not all costs are higher.

9 THE CHAIRMAN: And would business taxes
10 or property taxes be fairly comparable?

11 MR. THOMPSON: I don't know the answer to
12 that, Mr. Chairman, but I could find out.

13 THE CHAIRMAN: I was thinking there must
14 be some partial set-off, at any rate, or all these factors
15 that you have mentioned would produce a rather sorry
16 result from the company's point of view.

17 MR. THOMPSON: Oh, indeed, one of the areas
18 where we believe a good deal of efficiency can be genera-
19 ted is in the marketing costs, and I have some comments
20 that I would like to make about that, but I believe there
21 is nothing to prevent a Canadian company from putting up
22 a pretty good show in terms of marketing costs compared to
23 its American counterpart, if you think of the concept of
24 efficiency in spending marketing money.

25 THE CHAIRMAN: Because their marketing costs
26 are pretty high?

27 MR. THOMPSON: They are indeed.

28 Now I would like to talk for a moment about
29 Canadian compared to foreign drug prices.

30 The comparisons of drug prices in Canada and



1 in other countries, forming Chapter XVI of the Statement
2 of the Director of Investigation and Research to this
3 Commission, makes use of material presented to the
4 Kefauver Subcommittee, and quotes headlines appearing in
5 Canadian papers in 1959, to the effect that Canadian drug
6 prices were the highest in the world. No mention is made
7 in the Statement of the evidence in rebuttal given by
8 witnesses at the Kefauver Subcommittee hearings.

9 THE CHAIRMAN: Are you going to give us
10 some reference to those?

11 MR. THOMPSON: Yes indeed.

12 We feel it necessary to point out that too
13 frequently, when foreign or European prices are compared
14 with Canadian and U. S. Prices, the impression is given that
15 the North American drug industry subsidizes the European
16 market, that it manufactures a product here and markets
17 it abroad at greatly reduced cost. The knowledge that this
18 is not so may have been assumed by the Director in the
19 minds of his readers, but we must point out that a highly
20 erroneous impression is gained from a reading of this
21 chapter. We further take exception to the fact that no
22 attempt has been made to seek a reason for these lower
23 foreign prices.

24 The staff of the Kefauver Subcommittee,
25 at the hearings before that body, introduced several
26 criteria to dramatize "high" or "excessive" prices paid
27 by American consumers, one of those being that drugs can
28 be purchased in foreign countries at much lower prices than
29 in the United States.

30 In their statements and in colloquy with



1 committee members and staff, industry witnesses explained
2 that far lower costs of manufacture abroad coupled with
3 far lower consumer-income account for lower dollar prices.
4 Moreover, they produced evidence that the foreigner who
5 may pay less in dollars from his lower income pays as much
6 or more in hours of work to earn the price of his drugs.
7 The same is true in Canada.

8 Commenting on a staff chart showing lower
9 dollar prices to druggists for prednisone in Great Britain,
10 Brazil, Iran, Holland and Austria, than in the United
11 States, John T. Connor, President of Merck, testified as
12 follows: (Vol. 3, page 561-62*)

13 "...approximately 70 per cent of the
14 steroid pharmaceutical sales abroad are
15 of products produced wholly or in part by
16 our foreign subsidiaries or branches...the
17 consequence is that our costs are partially
18 or wholly determined by economic conditions
19 within the country of sale. We are all
20 familiar with the fact that foreign material,
21 labour and other costs of doing business are
22 frequently far below our own..."

23 And then further, he said:

24 "It is evident that where we have the
25 benefit of those lower costs, we can sell
26 our finished pharmaceutical products at a
27 lower price than would be possible in the
28 United States."

29 He also said:

30 "...a pharmaceutical detail man in England



1 is paid...about \$210 in U.S. money compared
2 with \$600 or more a month in the United
3 States."

4 On January 27th, Henry H. Hoyt, President
5 of Carter Products Inc., gave the following testimony in
6 reply to the Subcommittee's Exhibit 191 (Vol. 10, page
7 2320) which listed lower prices for meprobamate in some
8 foreign countries in 1959 (Vol. 10, page 2326-27):
9 And he said:

10 "...in trying to compare foreign prices
11 with United States prices, you have to take
12 into consideration all factors involved,
13 such as per capita income, real wages, and
14 so forth. For example, the per capita
15 income in the United States is 13 times as
16 much as in the Argentine, 8 times as great
17 as in Mexico, 2½ times more than in Germany
18 ...If the American people were living on
19 the same scale as the people in England,
20 the price of Miltown would be lower here,
21 too..."

22 THE CHAIRMAN: Mr. Thompson, are you
23 accepting that as a good economic argument, or are you
24 just quoting it?

25 MR. THOMPSON: I am just quoting it, Mr.
26 Chairman.

27 THE CHAIRMAN: Because there seems to be
28 some holes there. A high standard of living does not
29 necessarily mean that prices are higher than elsewhere.
30 It depends upon what you get for the money. You may have



1 a high standard of living, theoretically, without a very
2 high income in cash, in money terms, if the prices are
3 low enough.

4 MR. THOMPSON: Mr. Chairman, there has
5 been a tendency here to look at the retail price of a
6 product in, let us say, the Argentine or one of those
7 other countries, and translate it into American or Canadian
8 dollars by applying the going rate of exchange, and show
9 that as a comparison price.

10 We are suggesting that it is much more
11 reasonable to indicate the amount of effort on the part
12 of the individual needed to earn the money in both
13 countries, this actually gives you the standard of living.

14 MR. WHITELEY: But that does not have a
15 direct bearing on the costs?

16 ~~MR.~~ THOMPSON: Doesn't it bear on the
17 difficulty of obtaining the product?

18 MR. WHITELEY: For instance, you may have a
19 camel driver in some eastern company who is transporting
20 goods and his average wage may be extremely low, and you
21 may have a truck driver in the United States transporting
22 the same type of goods, and the cost of the truck and the
23 cost of the truck driver may be extremely high in terms
24 of commercial wages, but in terms of carrying those goods
25 over a mile, the cost in the United States may still be
26 far lower than driving a camel across the desert.

27 MR. THOMPSON: Well, Mr. Whiteley, I appreciate
28 that, but isn't it true that the thing that interests
29 people in regard to drug prices is fundamental. It is the
30 amount of daily effort that needs to be expended to maintain



1 a supply. This might be very high. It might take a high
2 proportion of the worker's time, or it may take an extremely
3 small proportion.

4 Isn't it important to consider the amount
5 involved? The suggestion is that applying an exchange
6 rate to the currency between two countries may not be a
7 valid measurement of the difference?

8 MR. WHITELEY: And it might not fully reveal
9 the situation. At the same time comparison of relative
10 wages may not be any more revealing.

11 MR. THOMPSON: Relative wages are an
12 important ingredient in the cost of manufacturing and
13 distributing drugs and with that question goes the freedom
14 of the manufacturer in setting his prices. He has to live
15 with wages in Canada if he is manufacturing and distributing
16 in Canada, and he can live with a much lower wage scale if
17 he is operating in Mexico, for instance.

18 MR. WHITELEY: It depends what his costs are
19 in comparison to the wage rate. You may have low wage
20 rates, but you may have an extremely low output, and the
21 cost in output may be higher with your low wages than with
22 high wages.

23 MR. THOMPSON: I understand.

24 MR. WAHN: Mr. Thompson, I believe the
25 Commission would like to ascertain whether in fact in
26 Europe labour costs, in these foreign countries, effective
27 labour costs are higher or lower than, say, in the United
28 States.

29 I think Mr. Whiteley has pointed out, a camel
30 driver perhaps is paid much less than a truck driver, but



1 he was buying in Vancouver at the rate of \$20.20 per
2 hundred. He bought them there. The price was very high
3 to him, being a person on a very low income, and his wife
4 needed about three hundred of them a year, I think it
5 was.

6 He made some enquiries and found he could
7 get some from Mexico City at \$6.25. He imported them and
8 paid the sales tax, and the import duties, and still landed
9 them in Vancouver for \$9.00, substantially less than half
10 the cost of buying them in Vancouver. According to him
11 they are made by the same company. There would be no
12 difference in the cost of manufacture. They are made in
13 the same place by the same company. There would only be
14 the matter of the merchandising, and the difference does
15 seem to be rather high.

16 I was wondering if what you are talking
17 about now would explain this sort of situation.

18 MR. THOMPSON: It is hard for me to comment
19 on the economics of the Sandoz company, but I am thinking
20 our company ought to go into that business. I do have
21 some comments about the relative prices, actually, of
22 production in Mexico and Canada.

23 THE CHAIRMAN: We have had other letters of
24 a similar kind as to relative prices in England and Canada,
25 and the difference is pretty substantial. It may be that
26 in the comparison between England and Canada, that there
27 is manufacturing done in England and in Canada by the
28 same company, or sometimes there are other companies and
29 you have a difference in the cost of manufacturing as well
30 as a difference in the cost of distribution. Where you



1 on the other hand he transports more of the product. So,
2 in effect the labour costs of the American truck driver
3 might be lower than the Arab camel driver. So therefore
4 I think the question that interests the Commission is
5 whether in your viewpoint the effective labour costs of
6 not only manufacturing but distributing and selling drugs
7 are higher or lower in these foreign countries than say in
8 the United States.

9 MR. THOMPSON: Well, I am sorry, Mr. Whiteley.
10 I think the answer is: You have discussed a camel and a
11 truck. In the pharmaceutical industry, the equipment is
12 basically the same. A tablet press is basically the same
13 in Mexico as it would be in Canada, but the cost of the
14 attendant who operates that press would be much lower in
15 Mexico, and the productivity would not vary by a great
16 deal, but the cost of the labour to create the production
17 would be much lower and is much lower. Similarly, the
18 cost of the detail man as was mentioned earlier.

2 19 THE CHAIRMAN: We have had some letters --
20 I am not going to say a great many, because there are not
21 a great many, but we have had several along the lines you
22 are talking about now, and I have one in front of me at
23 the moment from a man in British Columbia. It is not your
24 company he is referring to. It is not an American Company.
25 It is a Swiss company by the name of Sandoz. I don't know
26 whether they have a manufacturing plant in Mexico or in
27 Canada, do you know?

28 MR. THOMPSON: They have a plant in Canada,
29 but I have never been in it.

30 THE CHAIRMAN: There was one product which



1 only have the difference in the cost of distribution, you
2 would think the difference in price would not be as great
3 as where you have manufacturing as well in the low cost
4 country.

5 MR. THOMPSON: I think if we found that in
6 our company, we would do what they did with our
7 sulfamethazine plant and close it down and import.

8 THE CHAIRMAN: As far as this man was
9 concerned, it paid him to bring it in from Mexico.

10 MR. THOMPSON: I am sorry I cannot explain
11 it, Mr. Chairman.

12 THE CHAIRMAN: This was right along the
13 lines you have been speaking about and I was wondering
14 whether the explanation you have been giving would be the
15 explanation of what sometimes seems to be these remarkable
16 variations in price.

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/EMT/hm

1 MR. THOMPSON: I don't see how it could
2 explain that kind of difference. The manufacturer himself
3 could gain by importing, presumably. I am sorry, I can't
4 answer that question. I have another quotation that might
5 interest you, Mr. Chairman. This is an exchange that
6 took place between the Chairman and Alvin G. Brush, board
7 chairman of American Home Products Corporation (Vol. 10,
8 page 2408-10):

9 "Senator Kefauver: I want to say to begin
10 with that I can't understand why you sell
11 so low to them (i.e. foreign countries).
12 We have already put a chart in on meproamate.
13 I can't understand why you can sell so low
14 in England, for instance, why you can sell
15 so low in Germany.

16 MR. BRUSH: In the first place we don't sell
17 in dollars in England. We sell in pounds,
18 shillings and pence. We don't employ
19 Americans in England. We employ Englishmen.
20 These goods are entirely manufactured within
21 the British economy, and the cost of these
22 goods is materially lower than the costs in
23 the United States. A bus driver in London
24 gets 12 pounds a week which is roughly \$34.
25 The same man in the United States on the
26 Fifth Avenue bus gets \$110 a week. Now that
27 is an exaggerated part of the economy, but
28 we can do business in Britain for half of
29 what we can do business for in the United
30 States, and our goods in Britain are made in



1 Britain and sold in Britain, and are pro-
2 duced by British employees..."

3 He also said:

4 "You can buy transistors in Japan for one
5 quarter of what you can buy the same thing
6 in the United States...You can buy barbed
7 wire in Germany much cheaper than you can
8 buy the same barbed wire in the United
9 States. This isn't only true of the drug
10 industry. This is true of all prices..."

11 Mr. Brush again reviewed the elements of
12 manufacturing cost that are substantially lower abroad,
13 then added (Vol. 11, page 2601):

14 "...the only fair way to consider that (i.e.
15 price - ed.) is what it takes in man hours
16 to purchase a bottle of Equanil or any other
17 item of the individual. With meprobamate
18 we know it costs less in the United States
19 in terms of man hour income than in any
20 country in the world."

21 On February 23rd, Dr. Austin Smith, President
22 of the Pharmaceutical Manufacturers Association, intro-
23 duced further evidence that the U. S. dollar price tag is
24 no valid measure of the true cost of drugs to the average
25 man abroad. Taking the dollar equivalents of the price of
26 a leading tranquilizer in six countries as introduced in
27 Subcommittee Exhibit 98 on January 21 (Vol. 7, page 1544),
28 Dr. Smith presented the following table:

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30



	<u>Retail Price in</u> <u>U. S. Dollars</u>	<u>Hours of work to</u> <u>buy 50 tablets</u>
1		
2		
3	France .77	1 hr. 57 min.
4	U.S.A. 5.05	2 hrs. 18 min.
5	W. Germany 1.90	3 hrs. 18 min.
6	Italy 1.62	4 hrs. 46 min.
7	Japan 2.29	7 hrs. 38 min.

8
9 NOTE: Labour based on hourly earnings in manufac-
10 turing, U.N. Bulletin of Statistics; for
11 Japan, Time Magazine, Dec. 28, 1959.

12 The figure for the retail price in Canada
13 in the above table has been quoted by the Director in his
14 Statement at page 204, a figure of \$7.05. We calculate
15 the hours of work required to buy 50 tablets in Canada
16 would be somewhere in the region of 3 hours 49 minutes.

17 THE CHAIRMAN: That is on the basis of
18 average manufacturing wages?

19 MR. THOMPSON: Yes, it is, and that falls
20 in that table some place between West Germany and Italy.

21 Lederle's Achromycin 250 mg. capsules in
22 packages of 16 retail in both Canada (Federal Sales Tax
23 included) and the United States at a suggested list price
24 of \$7.11, and in packages of 100 at \$43.13. Prices to
25 consumers in some foreign countries in U. S. dollars (as
26 of September 1, 1961) are as follows:

<u>Achromycin</u>	<u>16's</u>	<u>100's</u>
27		
28	Columbia 5.84	34.62
29	Greece 7.16	38.61
30	Costa Rica 6.01	34.80
	Japan 6.00*	26.39
	Mexico 5.59	33.73



1 And Italy, \$5.81 for 16's, which is the only size available.

2 THE CHAIRMAN: Would those all be made in
3 the United States or in Canada and sold in these countries,
4 or has the company manufacturing plants in some of the
5 countries?

6 MR. THOMPSON: Mr. Chairman, I would have
7 to check to answer that question accurately, but I do know
8 that our company has a number of plants in the countries
9 listed here.

10 THE CHAIRMAN: From your information, wages
11 and so on in the different countries, if these goods were
12 made, Costa Rica we will say, or Japan, rather than made
13 in the United States and shipped there, I am just wondering
14 what the situation actually is with regard to that.

15 MR. THOMPSON: I do know, for example, we
16 have an antibiotic plant in Italy, and this plant exports
17 from Italy wherever it is economically sound to do so, to
18 other countries. Chances are these products are all made
19 abroad, but if you would like a definite answer to that,
20 I would be glad to supply it to you separately.

21 THE CHAIRMAN: There was a substantial
22 difference between some of these prices and the prices in
23 the United States and Canada, but not as much as might be
24 expected in view of the extreme variations in wages in some
25 of these countries compared with the United States.
26 Assuming that your company would have an up-to-date plant
27 there.

28 MR. THOMPSON: The matter of manufacturing
29 cost is not the only ingredient that sets a lower limit on
30 the selling prices. Cost of marketing has to be considered



1 also.

2 THE CHAIRMAN: And again the wages would
3 be much lower in those countries?

4 MR. THOMPSON: Yes, so that even if the
5 product were exported from the United States at a relatively
6 high production cost, the marketing increment from it might
7 be much lower there than in the United States.

8 THE CHAIRMAN: I was rather expecting that
9 if there is manufacturing as well as marketing in some of
10 these countries, the difference between prices there and
11 the United States might be even greater.

12 MR. THOMPSON: I would be glad to find out
13 for each of those countries. Would you be interested?

14 THE CHAIRMAN: I would be interested in
15 getting as complete a picture as we can. This is one of
16 the things that puzzles us, these wide variations, and if
17 we could get the complete story it would help us quite a
18 bit to understand the great difference that do exist
19 between one country and another.

20 MR. THOMPSON: I would be glad to get that
21 information for you.

22 THE CHAIRMAN: As you have finished with
23 this section, perhaps we might have a short break at this
24 time. We will be adjourning for lunch at 12:30, and we
25 will have a short break at this time.

26

27 ---Short recess.

28

29 THE CHAIRMAN: We will resume the hearing.

30 MR. THOMPSON: Mr. Chairman, a few moments



1 ago you asked a question about the variable costs in
2 foreign countries as compared to the United States and
3 Canada, and I intend to give you a more detailed answer,
4 but I can add one thing to the information that I gave you
5 before the adjournment.

6 Our company has 50 plants around the world
7 in different countries, and these plants are geared to
8 varying degrees of manufacture. Not all of them make
9 antibiotics at all, and the ones that do, export to other
10 countries, so that antibiotics produced in England, for
11 example, are exported to France.

12 The degree of processing in France may be
13 different than the degree of processing in another European
14 country, so that there is a complex interrelationship in
15 which each country seeks its most economical source,
16 usually from within a company. Our answer will be framed
17 in that rather complicated reference.

18 Also there are some other factors I have
19 listed here that are factors in cost, and our experience
20 is all of these are normally lower in other countries,
21 particularly in Europe and South America. Some of these
22 items are taxes, depreciation, capital investment, wages
23 of manufacturing employees, and all marketing employees.
24 The cost of employee benefits, such as pension plans and
25 health insurance, are lower, and of course the distribution
26 costs, shipping charges, warehousing expenses, are all
27 lower in those countries, and these are some of the factors
28 that will be in our answer to you.

29 THE CHAIRMAN: Would taxes be lower in
30 Britain?



1 MR.THOMPSON: Some of the taxes are lower
2 in Britain. Income tax I think is higher, but I am not a
3 tax expert. There is great encouragement in Britain of
4 course to set up local manufacturing.

5 Next I would like to talk a bit about
6 profits.

7 The commercial companies are in business to
8 make a profit, and to the extent that the free enterprise
9 economy relies upon commercial companies to develop their
10 products, we must recognize that the rate of development
11 must depend upon the rate of profit and that the results
12 obtained during the past years in increased health and
13 welfare have justified the prices paid.

14 The drug industry is a high-risk industry.
15 This means that a drug manufacturer must anticipate that
16 his sales may drop by a substantial percentage on very
17 short notice upon the introduction of a competitive product.
18 It has furthermore been pointed out that the lifetime of
19 a particular antibiotic may be extremely limited in this
20 expanding industry.

21 The rapid obsolescence caused by the develop-
22 ment of new drugs is illustrated by the example of
23 antipneumonia sera. Twenty-five years ago, American
24 Cyanamid was a leading producer of anti-pneumonia sera
25 which was then the only effective treatment for pneumonia.
26 Yet Cyanamid's investment of over half a million dollars
27 in the antipneumonia sera was nearly wiped out within a
28 year by the introduction of the sulfa drugs. Cyanamid
29 immediately went to work in the sulfa field and developed
30 a valuable new sulfa compound, Sulfadiazine, which was a



1 potent weapon against a wide range of infections, as well
2 as pneumonia.

3 Most of the major drugs since the advent
4 of penicillin have been developed in the research centres
5 of American commercial enterprises. The tranquilizers,
6 the steroids and the broad spectrum antibiotics have with
7 few exceptions originated or have been commercially
8 perfected by these companies.

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1 In no other country in the world has the
2 development of drugs paralleled that in the United States.
3 One of the main reasons for such phenomenal advances has
4 been the prospect of financial returns. As Mr. Andre
5 Forget, a Montreal lawyer and himself a patent expert,
6 said in a recent address to the Canadian Pharmaceutical
7 Manufacturers Association:

8 "...There is nothing immoral or unethical
9 in reaping a reward for inventing a drug.
10 On the contrary, drugs are for the relief
11 of suffering and the cure of disease, and
12 if the manufacturer of a ballpoint pen that
13 can write under water can make a fortune out
14 of his invention, surely the man who invents
15 a drug that will cure cancer is entitled at
16 the very least to as much reward. The case
17 of insulin is well known. Drs. Banting,
18 Best and Collip patented that drug and this
19 enabled their assignee, the University of
20 Toronto, to collect considerable amounts of
21 fees which were ploughed back into research.
22 The results have been most happy".

23 On page 149 of the Director's Statement are
24 reproduced figures compiled by the United States Federal
25 Trade Commission showing that during the years 1958-59 in
26 the U.S. the drug manufacturing industry apparently enjoyed
27 the highest profits per dollar of sales of any industry
28 group in the economy.

29 But Raymond Moley, writing in Newsweek for
30 September 4, 1961, had the following observations to make



1 concerning the profits of U.S. drug companies:

2 "But if the markups by the manufacturers are
3 excessive, it would follow that their profits
4 would be out of line with those of industries
5 selling other products. In the Kefauver
6 Report, this is dealt with in tables....of
7 figures published by Fortune Magazine for
8 the year 1958. Companies are rated accor-
9 ding to two criteria: profits after taxes as
10 per cent of invested capital and as per cent
11 of sales.

12 In the top 50 companies there are ten drug
13 concerns in the first table and nine in the
14 second table. Among the 50 in each case,
15 drug manufacturers are neither highest nor
16 lowest. In the first table two drug compa-
17 nies are among the first ten. The others
18 are Gillette, Revlon, Avon Products, Chem-
19 strand, Champion Spark Plug, Botany Mills,
20 Brunswick, Pepsi-Cola. In the second table
21 there are three drug companies among the
22 first ten. The others are Amerada Petroleum,
23 Ideal Cement, Dupont, Standard of California,
24 Champion Spark Plug, Lone Star Cement, Inger-
25 soll Rand.

26 In Fortune for July, 1961, similar compari-
27 sons are shown for 1960. Here among the
28 top ten there are three companies that manu-
29 facture drugs, two of which make so many
30 other products that only one is properly a



prescription drug company. The others are Commonwealth Oil, Gillette, Avon Products, Brunswick, Champion Spark Plug, Tecumseh Products, Libbey-Owens-Ford. In the second table there is only one drug manufacturer. The others are Amerada Petroleum, Dupont, Union Texas Natural Gas, Superior Oil, Champion Spark Plug, Gillette, Kern County Land, Standard of California, Kennecott Copper.

Thus the drug manufacturers are not by comparison with other representative industrial companies making excessive profits. All the companies mentioned have patents of one sort or another. All advertise and carry on vigorous sales efforts. This is the record, despite....efforts to make it seem otherwise".

Canadian figures on individual company profits are not available to the same extent as in the U.S. On page 151 of his Statement, the Director has reproduced figures from the Department of National Revenue, 1960 Taxation Statistics, for the 1958 taxation year. On this list "pharmaceuticals" are classed as one of the divisions of the chemical industry, with a profit rate before taxes of 10.5%. Not shown in the list, however, are numerous divisions in many of the other major classifications, quite a few of which divisions show a higher profit rate than that for pharmaceuticals. Among these are the following:

(a) Food and beverages

(1) Alcoholic Beverages 16.8%



(2) Carbonic Beverages 12.6%

(b) Paper Products

(1) Pulp & Paper Mills 11.8%

(c) Non-metallic mineral products

(1) Abrasives, Asbestos, Cement

and Clay Products 11.2%

In addition, Primary Iron & Steel Production, a division of Iron and steel products, enjoyed a profit rate of 10.4% - only .1% less than the 10.5% enjoyed by pharmaceuticals.

Furthermore, the Director has said at page 241, that the more informed critics of the industry do not inveigh against high profits as such (which we think is a rather charitable commentary on the critics) but that their main complaint is against alleged wasteful expenditures such as promotional and other activities.

THE CHAIRMAN: Mr. Thompson, just to be sure, these rates given for food and beverages, paper products, etc., are profits on sales or on capital investment?

MR. THOMPSON: Profits on sales. That is in the same terms as the figure for pharmaceutical manufacture.

Now it might be interesting to talk about promotion and selling activities.

PROMOTIONAL AND SELLING ACTIVITIES

It is an absolute necessity for pharmaceutical manufacturers, in order to be competitive, to engage in the practice of acquainting the members of the medical profession, pharmacists and the institutions which dispense medication, of the latest developments in the industry. Advertising to the public is forbidden by law, but the inevitable consequence of this law is that the manufacturer



1 must still communicate with his consumer who in this case
2 is not the public but rather the medical profession,
3 pharmacists and the institutions. That this is costly
4 there is no doubt.

5 In this connection, however, we must call
6 attention to an allegation repeatedly made against
7 American Cyanamid, which has found its way into the
8 Director's Statement (page 59) and was reiterated by Dr.
9 Schecter before this Commission, to the effect that
10 American Cyanamid had spent some \$2,000,000 in introducing
11 Aureomycin by means of free samples. The original state-
12 ment in the U.S. Federal Trade Commission's Economic
13 Report on Antibiotics Manufacture (June, 1958) at page 140,
14 reads as follows:

15 "When American Cyanamid introduced Aureo-
16 mycin in 1948, ten carloads of samples were
17 mailed to about 142,000 physicians. It has
18 been estimated that the cost of the product
19 alone was about \$2,000,000".

20 As the footnote in the Report, this quotation came from a
21 thesis by a university student who had never, to our know-
22 ledge, contacted the company about this matter. The truth
23 of the matter was that a generous mailing of samples was
24 made, but the cost was nowhere near \$2,000,000. Actually,
25 the cost was \$1.25 per physician, to 142,000 physicians,
26 for a total cost on this mailing of less than \$180,000.

27 THE CHAIRMAN: That is the cost of the
28 sample itself?

29 MR. THOMPSON: Yes.

30 THE CHAIRMAN: Not the cost of mailing, and



1 the rest?

2 MR. THOMPSON: No, I am sorry, that is the
3 total cost Mr. Chairman of the package. This was a
4 package in which was included samples, and I am quoting
5 the total cost per physician in the mail.

6 THE CHAIRMAN: After paying postage?

7 MR. THOMPSON: After paying postage, yes.
8 That is why I said a total cost on the mailing.

9 Drug advertising is a specialized art. We
10 must deal with doctors, a profession notoriously and
11 properly skeptical by training. Promotional campaigns to
12 doctors and pharmacists are carefully planned and executed.
13 To the charge that such programs are wasteful, we can only
14 answer that we as a commercial organization are averse to
15 spending money where it is of no avail to do so. The
16 methods used - journal advertisements, direct mail, and
17 personal calls - are the result of experience acquired
18 over a considerable period of time - since 1879 when this
19 industry started in Canada - as to the most effective way
20 of communicating what must be told. From time to time,
21 these methods change and modify to suit the changing
22 conditions in the industry.

23 Since mass media communication is banned by
24 law, the most effective method of communicating with
25 doctors is by the personal call. There are approximately
26 20,000 doctors in Canada, spread thinly from Newfoundland
27 to British Columbia. They are all busy men, and the
28 demands on their time are probably far beyond those on
29 any other professional or business man in this country.
30 Our representatives make every effort to spend a few



1 minutes with most of these doctors on the average of not
2 quite four times a year. It is a difficult task, and they
3 do well to call on six doctors per day. If these doctors
4 all lived in large centres, it would be much more simple
5 and less costly to communicate with them. But this is
6 not so, and therefore these men must travel great
7 distances - often to very remote areas - to call on a
8 single doctor.

9 We also have a full-time Medical Director,
10 who has been introduced to you, who is a licensed physi-
11 cian and a graduate of the University of Toronto Medical
12 School. We encourage physicians to contact this qualified
13 physician, who is always ready to answer questions about
14 our drug products.

15 Accusations have been levelled at the
16 industry for the quality of its direct mail advertising,
17 and further that this form of advertising is unnecessarily
18 expensive. Our total direct mail expenses for literature
19 sent to physicians in Canada in 1960 amounted to \$61,400,
20 which, on the basis of some 17,000 physicians on our
21 mailing list, represents a cost for direct mail per doctor
22 of only \$3.61. It has been claimed that the bulk of
23 direct-mail advertising goes unread, and even unseen, by
24 the majority of doctors. This is simply not so. Our
25 representatives, when they call on doctors all over
26 Canada, are repeatedly assured that direct mailings are
27 in fact read by the doctors, are welcomed by them, and
28 are considered by them to be informative and useful.
29 Some doctors, notably medical school professors, have
30 testified that they are inundated with an avalanche of



1 excessive and uninformative advertising which they believe
2 is both wasteful and too commercial, but this view is
3 definitely not shared by most practising doctors.

4 THE CHAIRMAN: That statement is on reports
5 from your representatives?

6 MR. THOMPSON: Yes.

7 THE CHAIRMAN: Based on their reports?

8 MR. THOMPSON: Yes. We have had a number
9 of occasions when representatives would walk into a
10 physician's office, mention a product, and the doctor
11 would say why I got that in the mail a few days ago.
12 The physician would know of the product which he would
13 otherwise not have heard about.

14 THE CHAIRMAN: That is good timing, of
15 course.

16 MR. THOMPSON: We don't always do it that
17 well Mr. Chairman. That is one of the purposes of direct
18 mail; is to rouse the physician's interest so that the
19 salesman, when he visits him, can make more efficient use
20 of his time.

21 THE CHAIRMAN: Yes, he knows about the drug
22 if he has received it; at least, if he had looked at it
23 at all he knows what it looks like and has some idea of
24 what it is made of. Then, also, I suppose the samples
25 the doctors might use them for some of their patients who
26 might not be able to afford them otherwise.

27 MR. THOMPSON: Yes. Sampling is a sort of
28 subject unto itself. I would like to talk about that a
29 little later. We often find that where a physician has
30 heard of a drug through direct mail advertising, he is



1 ready and anxious to see the salesman so that he can ask
2 questions about it. This is one of the purposes of direct
3 mail.

4 There has been much criticism that toxicity
5 and side-effects are not sufficiently known by the members
6 of the medical profession. Our index cards supplied to
7 physicians contain completely adequate statements as to
8 the possibility of side-effects, which statements are in
9 no way attempts to "gloss over" these side-effects (as was
10 indicated in earlier testimony before this Commission).

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1 Furthermore, it is far better to disclose
2 than to conceal side-effects, for otherwise the drug
3 product and the drug manufacturer would soon become
4 regarded with distrust.

5 Mr. Chairman, I have some samples of the
6 index cards I referred to. This is one describing an
7 antibiotic which has reference to the generic name in at
8 least half-a-dozen cases. For example, there is a para-
9 graph of precautions. I suggest that the data on the
10 inside are sufficient for any physician to use the drug
11 intelligently and safely.

12 THE CHAIRMAN: Would you like to file one
13 of these?

14 MR. THOMPSON: I would like to very much,
15 if I may. I have several samples.

16 THE CHAIRMAN: I will mark that as Exhibit
17 T-1, index card for declomycin.

18
19 --- EXHIBIT NO. T-1: Index card for declomycin
20

21 MR. THOMPSON: I would also like to file
22 another example, Artane.

23 THE CHAIRMAN: We will mark the index card
24 on Artane as Exhibit T-2.

25
26 --- EXHIBIT NO. T-2: Index card on Artane
27

28 MR. THOMPSON: The principal purpose of
29 medical journal advertising is not to try to teach the
30 doctor about the drug, but to remind him of its existence



1 and sometimes to make suggestions which may lead him to
2 consult the more complete information which is readily
3 available. The busy practitioner, unless reminded of
4 drug products through journal advertising, may overlook
5 the suitability of a particular drug for a particular
6 disease.

7 In that regard, Mr. Chairman, we have found
8 it necessary to key our market on declomycin progressively
9 to one type of disease, one type of infection after
10 another for which it is suitable so a well-rounded picture
11 would be directed to the physician. We find just listing
12 10 or 20 types of organisms or infections, the physician
13 simply does not remember them all.

14 THE CHAIRMAN: Ten or twenty organisms it
15 will attack, so you will have 10 or 20 advertisements;
16 is that it?

17 MR. THOMPSON: Over a period of time, yes.

18 Thus far, we have concentrated on the
19 methods of promotion to doctors. It is equally essential
20 that promotion of pharmaceuticals to drug store pharma-
21 cists must keep pace with that to doctors and institutions.
22 The U.S. Federal Trade Commission Economic Report on Anti-
23 biotics Manufacture, at page 127, makes this position clear
24 in the following passage:

25 "Drug-trade advertising is more important to
26 the success of an 'ethical' product than is
27 generally realized. Although it is the
28 physician who activates the sale, it is the
29 druggist who actually rings the cash register.
30 If the product which a physician prescribes



1 is not in stock at the local drug store and
2 the druggist cannot get it quickly from his
3 jobber, a most unfortunate series of sales-
4 killing events can take place. The druggist,
5 of course, is not at liberty to change the
6 physician's prescription. But he is free to
7 'phone the prescribing physician, suggesting
8 a change to a competing product. When this
9 happens, more harm is done than simply the
10 loss of a single sale. Neither the physician
11 nor the pharmacist appreciates being placed
12 in this position, and their future attitude
13 toward the original product can be most
14 uncooperative. Thus, adequate drug-trade
15 distribution must parallel the promotional
16 campaign to physicians, and advertising to
17 druggists plays an essential part in
18 achieving this distribution".

19 To this end, our Lederle drug representatives in Canada
20 spend a considerable amount of time with the drug trade,
21 in order to make sure that the pharmacists know about our
22 products and that our products will always be available
23 when needed.

24 There has been testimony before this Commis-
25 sion that the practice of distributing free samples of
26 drugs to physicians is a wasteful one. But samples have
27 a great many uses for the doctor. In the first place, it
28 is important for a doctor to be personally acquainted with
29 a new drug and its results before he prescribes it with
30 confidence.



1 Another important use of samples is for
2 initial dosage. There is no drug which can be tolerated
3 equally well by all patients. Doctors find samples
4 extremely useful for beginning treatment with the patient
5 whose ability to tolerate the drug has not been established.
6 Doctors also like to have samples in their bag so that they
7 can begin treatment immediately at times when there may be
8 delays in filling prescriptions through a drug store - for
9 example, in making house calls at night. This is particu-
10 larly true for drugs such as antibiotics which are used to
11 combat serious infections.

12 Furthermore, doctors frequently use samples
13 in the treatment of patients in poor financial circumstances.

14 It is no doubt true that samples of some kinds
15 of drugs are more valuable than other kinds to the doctor.
16 Cyanamid does not sample all its products indiscriminately
17 but is guided in accordance with what it finds doctors
18 want. We have no doubt that the great majority of practi-
19 sing physicians welcome and use our samples and would not
20 want us to discontinue them.

21 One other point relating to promotional
22 activities should be mentioned here. It has been suggested
23 by Dr. Gemmell in his remarks to this Commission that the
24 prices of drugs should appear in printed material sent to
25 the doctors. It must be pointed out that if Cyanamid
26 printed the retail or suggested list price in its drug
27 advertisements, it would impose an injustice on druggists.
28 The costs to druggists of doing business differ, and they
29 must have the freedom to establish an appropriate markup
30 to cover their costs plus a reasonable profit. This



1 freedom would be interfered with by any publication of
2 suggested retail prices in printed material sent to
3 doctors.

4 An additional argument against the insertion
5 of a price list on brochures and mail material to doctors
6 is that different products having different prices will
7 have correspondingly different dosages, and this latter
8 fact might be overlooked in a brief comparison of prices
9 of similar products, and it would therefore be impractical
10 and highly inadvisable to compare them on the simple basis
11 of price.

12 THE CHAIRMAN: Mr. Thompson, as a matter of
13 practice do your detail men tell the doctors what the
14 suggested retail price would be?

15 MR. THOMPSON: Oh yes, indeed, our detail
16 men are well-informed on prices because of their work with
17 the drug trade and they are always willing to discuss
18 prices. When a specific question is asked they try to
19 give a specific answer. They also have knowledge of
20 local drugs, retail drug costs.

21 THE CHAIRMAN: We have had some evidence from
22 some doctors they are not familiar with the prices of the
23 drugs. They are concerned primarily about what the effects
24 will be on the patient. Some others have said they know
25 fairly well what the prices are. I was wondering what the
26 practice of your detail men was, to tell them what the
27 price was so they would know when they are dealing with
28 patients they realize have very little money to spare,
29 whether the prescription he is proposing is going to be a
30 very serious burden or not.



1 MR. THOMPSON: Indeed, Mr. Chairman, our
2 men are expected to discuss price whenever the question is
3 asked and further, in some cases, suggest the most econo-
4 mical size of prescription for the patient. The package
5 is generally geared also, for example, one of our packages
6 contains 28 tablets, which is one week's supply. This is
7 done because it is the most economical way of getting that
8 package to the consumer through the hands of the retail
9 pharmacist.

10 THE CHAIRMAN: Is the package sometimes
11 geared to what you might call the period of treatment?

12 MR. THOMPSON: Yes.

13 THE CHAIRMAN: So that you might have 28 or
14 20 tablets, whatever it is, because the rate at which the
15 patient is supposed to take it will run through what they
16 consider a series of treatments at the time the package
17 is used or about that time?

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2 MR. THOMPSON: This is the reason, for
3 example, Declomycine was packaged in bottles of 16
4 capsules.

5 THE CHAIRMAN: You should take the 16
6 over a period?

7 MR. THOMPSON: Yes, it is the most
8 useable amount needed.

9 I would like to talk a little bit about
10 brand names and generic names.

11 It has been said that generic named drugs
12 are invariably cheaper than brand name drugs. When
13 generic name drugs are spoken of in this sense, the
14 speaker is usually referring to the drugs marketed by the
15 importers and small manufacturers. In fact, every company
16 of any size is both a generic and a brand name manufac-
17 turer. Its products have the generic name on the label
18 and also have the company's brand name. The brand name
19 has grown up partly as convenience, due to the length
20 and cumbersomeness of generic names, which are frequent-
21 ly difficult to remember and to read on a doctor's
22 prescription. It also serves as a means for disting-
23 uishing the company's product.

24 Cyanamid will sell to any qualified buyer
25 who orders by generic name. It is to be noted that the
26 price for the drug purchased under the generic name is
27 precisely the same as if it were purchased under the
28 trade name. This indicates that mere prescribing by
29 generic name will not necessarily mean that the drug
30 will be cheaper to the consumer. If the doctor simply



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2 prescribes a drug by the generic name, there is no
3 guarantee that the dispensing druggist will dispense to
4 the patient the cheapest product or indeed that if he
5 does, he will pass on the saving to the purchaser.
6 Indeed, this has been stated a number of times by
7 practising pharmacists before this Commission.

8

9 The Director concludes in his Statement
10 at page 13, paragraph 28, that a trade name is no
11 guarantee of quality or purity. This statement, we feel,
12 is an ambiguous and slightly misleading one. A truer
13 statement might be that a trade name is not necessarily
14 a guarantee of quality or purity; but the essential
15 fact remains that it can be and frequently is a
16 guarantee of quality by virtue of the reputation which
17 the owner of the trade name has attained over a period
18 of years for quality and purity in its products. It
19 would take only one lot of faulty drugs with a brand
20 name to damage seriously the reputation of its manufacturer.

21

22 Cyanamid publishes the generic name along
23 with the trade name in its advertising and literature
24 distributed to the medical profession. This appears
25 clearly, for example, on an index card for Declomycin.

26

27 I think you will find it, Mr. Chairman,
28 on the one I filed with you.

29

30 The trade name is followed immediately
31 with the generic name "demethylchlortetracycline". The
32 generic name is also mentioned frequently in the text.
33 This index card is made in a form to be kept in a
34 permanent file by the doctor.



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2 The doctor is indeed free to prescribe
3 by generic rather than trade name if he prefers to do
4 so. But, as the person to whom the patient entrusts his
5 health and medical care, the doctor must reserve the
6 right to make his own decision as to whether a product
7 in which he has greater confidence should be furnished
8 to his patient, and hence the right to prescribe or
9 order a particular drug product of a named manufacturer.
10 It is inconceivable that the doctor should lose the
11 right to steer his patient clear of a product in which
12 he has no confidence. He must always have the right to
13 prescribe the drug of his choice.

14 We have no intention of lowering our
15 standards under competitive pressures because we know
16 that doctors demand the highest possible standards of
17 quality control. Even some of the medical profession
18 who have criticized certain of the drug industry's
19 practices agree that prescription by trade name is
20 essential in their practices. Witness the example
21 indicated by Dr. Gemmell in his testimony before this
22 Commission. Also, Dr. Morrell of the Food and Drug
23 Directorate of the Department of Health testified that
24 while he does not object to prescribing by generic name,
25 he also wants the right to insert the name of the company
26 after the generic name. In effect, this is prescribing
27 by trade name, but more difficult for the physician
28 because he must remember three things: the generic
29 name, the company name, and which company goes with
30 which generic name. A single trade name does all three



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2 for him.

3 It must also be remembered that two drugs
4 considered to be the same generically may vary as to
5 additives or excipients that could make a difference
6 to the absorption of the drug by different patients. The
7 doctor should not be deprived of his right to pass on
8 these matters.

9 We could quote much lower prices on some
10 popular antibiotic if, like the imitator, we concentra-
11 ted upon existing drug forms that were the largest
12 sellers, after the expensive promotion had already been
13 paid for and after the drug had won the confidence of
14 the medical profession. Cyanamid maintains a broad
15 product line, many of the items of which have little or
16 no commercial significance even though they may be of
17 vital medical importance in particular cases. Examples
18 of these are such life-saving drugs as tetanus and
19 botulism antitoxins, on which we lose money annually.
20 Furthermore, we maintain a countless variety of
21 different dosage forms of the drug involved and keep our
22 products stocked in 4,860 drug stores across the
23 country. Most imitators do not offer this kind of
24 variety or service. They take a few popular forms of a
25 widely used product that has already been successfully
26 promoted to, and accepted by, the medical profession.
27 They do not attempt to manufacture and distribute the
28 less popular and therefore less profitable forms. It
29 is always possible for the imitator in any industry to
30 under-sell the large creative manufacturer. He can sell



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2 more cheaply to institutions who buy generic name because
3 he has no marketing operation and no research costs. As
4 for the much larger retail market, in order to effect
5 sales to the public through drug stores by means of
6 doctors' prescriptions, he has to build a marketing or-
7 ganization. Once he has done this, he has to make sure
8 that he is not merely creating business for someone else.
9 He must find a way to persuade the doctor to specify
10 the product of his manufacture. One way is to suggest
11 that if the doctor will prescribe by generic name, that
12 he attach the manufacturer's name after the generic name
13 as, for example, as seen in this plea on page 2 of the
14 Gilbert Surgical News for May 1961, where Mr. Gilbert
15 suggests writing the prescription under its generic name
16 and specifying "Gilbert".

17 THE CHAIRMAN: Do you wish to file that
18 as an exhibit, Mr. Thompson?

19 MR. THOMPSON: I would like to later,
20 Mr. Chairman. I am not quite through with it.

21 It is a far easier thing for a physician
22 to remember a brand name, so the manufacturer develops
23 his own brand name as, for example, Gilbert appears to
24 be doing. This is "Gilbert Surgical News" and contains
25 an insert which describes a treatment of arthritis by
26 nicotinic acid and nicotinamide, and on the back are two
27 of Mr. Gilbert's products, one with the name "Nyasal"
28 which appears to be the coin name, and another one
29 similar to it. If I may, I will leave this with you,
30 Mr. Chairman.



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THE CHAIRMAN: This material which has just been referred to from Gilbert Company and described as "Gilbert Surgical News" will be Exhibit G3.

One of the most vital factors in the brand name manufacturer's product is quality control. In the Director's Statement, on pages 108-110, there is a tabulation indicating that in the case of 27 selected firms (our own included) the cost of quality control expressed as a percentage of net sales ranged from nil to 2.65%. We feel that such a tabulation to a very large degree ignores the modern concept of quality control, and for this reason is very misleading. Perhaps we should examine briefly what we mean by the modern concept of quality control. The old concept is that when you have a laboratory technician or a chemist testing finished batches of material, you have quality control. This in fact is only a very small part of a properly organized control program, but it is the only element of quality control which is easily costed.

The modern concept of quality control of which I speak goes far beyond the mere testing of a finished product against certain standards. It is concerned with the procurement and specifications of raw materials, containers, labels and packaging supplies, the methods of production and assay, the testing procedures employed during the various stages of manufacture, the proper sampling during manufacturing, and the methods of storage and the manner of shipment to the customer.



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2 Our concept of proper quality control
3 does not end with the shipment of a bottle of tablets to
4 our customer. It is the function of quality control to
5 continue to perform stability tests, for example, on
6 individual field batches, comparing results against
7 standards established on the basis of previous experience
8 and taking appropriate corrective action when and if
9 necessary.

10 Quite naturally, the percentage of the
11 sales dollar spent on quality control will depend in
12 very large measure on which of these two concepts of
13 quality control is being used - the old or the modern.
14 In many instances, the accounting techniques being
15 utilized by the pharmaceutical industry have not as yet
16 been developed to reflect adequately the true cost of
17 the modern concept of quality control. These two factors
18 must be considered in evaluating the tabulation submitted
19 by the Director.

20 There is no question but that the costs
21 of quality control could be substantially reduced in the
22 pharmaceutical industry if the standards of quality
23 control could be safely reduced to the level of those
24 being used for non-drug items, such as automobiles,
25 hardware, etc. There are those who say that this can
26 be done, but we cannot agree. The modern concept of
27 quality control in the pharmaceutical industry is the
28 best insurance that the consumer will receive consistent-
29 ly safe and effective pharmaceutical products.

30 One of the many factors of quality control



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2 which enters into the total cost of doing business on a
3 national scale, but which is very often overlooked by
4 our critics is the problem of returns from customers of
5 unsold or outdated merchandise. The severity of this
6 factor will vary from company to company depending on
7 what proportion of a particular company's product mix
8 is merchandise which by government regulation must
9 carry an expiration date. A company such as ours with
10 a large number of antibiotic and biological products in
11 a wide variety of dosage forms will incur heavier losses
12 from returns of outdated merchandise than will a company
13 concentrating on only one or two dosage forms or on
14 products which do not carry expiration dates.

15 In Canada all antibiotics, regardless of
16 dosage form, must carry an expiration date. The dating
17 varies with the dosage form and the antibiotic itself.
18 For example, Declomycin Capsules carry a three year
19 expiration date, whereas Declomycin Pediatric Drops
20 carry a one year expiration date.

21 It is an element of our published policy
22 to accept for full credit as a return from our customers
23 any product in an unopened package which becomes outdated
24 in the customer's stock. In 1960, for example, such
25 returns amounted to more than 3% of our total sales.
26 On individual products carrying relatively short expir-
27 ation dates, such as one year from date of manufacture,
28 it is not unusual to experience returns of over 10%.

29 Since we were the first company to make
30 available supplies of Asian 'Flu Vaccine in Canada in



1
2 the fall of 1957 to combat the spread of Asian 'Flue,
3 our 1957 sales of this vaccine were naturally quite large.
4 However, this product carried an expiration date of 18
5 months when properly stored under refrigeration. As the
6 material remaining in our customers' stocks became
7 outdated in early 1959, our returns mounted. Over 10%
8 of the vaccine sold during this Asian 'Flue epidemic in
9 the fall of 1957 has been returned to us for full credit,
10 and because of the nature of this product, these returns
11 have no salvage value to us, and are destroyed as they
12 are received from our customers.

13 In fact, over 90% of all returns are
14 destroyed as non-salvageable, the only items that can
15 be salvaged being items in good date, packed in pilfer-
16 proof sealed packages, and not requiring refrigerated
17 storage. Unless we are absolutely certain that a package
18 could not have been opened after it left our possession
19 originally, we do not attempt to offer this package for
20 sale a second time. This again is an example of our
21 concept of our total quality control.

22 Now, Mr. Chairman, I have some remarks
23 on competition.

24 We are further accused by the industry's
25 critics, in the words of the Director in his summary at
26 page 242, of "the concentration in some research on the
27 development of saleable products rather than on the
28 advance of scientific knowledge". If this means that we
29 have introduced products which are competitive with
30 products already existing on the market, it can only be



1
2 stated that this is a characteristic of all industry on
3 this continent. We have introduced no product which did
4 not face competition from the start. There is no broad
5 spectrum antibiotic that does not face competition from
6 other broad spectrums as well as from penicillin and
7 the sulfas. If, on the other hand, the statement means
8 that we are mere copiers, then the charge could not
9 seriously be made against Lederle, and I do not propose
10 to take the Commission's time in attempting to refute
11 it. Suffice it to say that in the field of research
12 Lederle is an acknowledged leader among those organi-
13 zations which are characterized as creators - the
14 companies which are heavily committed to fundametal
15 research. The mere fact that a newly introduced product
16 entices competition from new or already existing products,
17 cannot be interpreted as mere copying alone.

18 As an illustration of the nature of
19 competition in the drug industry, we propose to review
20 briefly the marketing and pricing history of antibiotics
21 in Canada.

22 Three years after the end of the war,
23 American Cyanamid developed and marketed the first of
24 the broad spectrum antibiotics, chlortetracycline, under
25 its trade name, Aureomycin. This drug represented a
26 revolutionary advance in medicine and was effective
27 against a far broader range of infective organisms than
28 had been any previous drug. Also, it could be taken by
29 mouth rather than by injection. It was introduced in
30 Canada in February, 1949, at a suggested list price



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2 (Federal Sales Tax included) of \$21.40 for a bottle of
3 16 capsules, 250 mg. The initial price was well below
4 that indicated by the usual considerations, such as
5 estimates of initial production and marketing costs,
6 which promised to be extremely high.

7 Aureomycin rapidly attained wide usage
8 among doctors over North America. Early in 1949, Parke-
9 Davis introduced another broad spectrum antibiotic,
10 Chloromycetin, and early in 1950 Chas. Pfizer & Co.
11 brought out another, Terramycin. Thus, within about a
12 year and a half, instead of being the only producer of
13 broad spectrum antibiotics, Cyanamid became one of three
14 competing producers.

15 THE CHAIRMAN: At the end of the
16 preceeding paragraph, the initial price was well below
17 that indicated by the usual considerations, such as
18 estimates of initial production and marketing costs,
19 which promised to be extremely high, you mean the
20 company was taking an intelligent gamble as to what might
21 happen? Well below what would be the usual sort of
22 price?

23 MR. THOMPSON: Yes, the company gambled.
24 I have a remark on that in the next paragraph.

25 THE CHAIRMAN: I am sorry.

26 MR. THOMPSON: American Cyanamid
27 Company had gambled that through improvements in pro-
28 cessing, production costs could be substantially reduced,
29 and through eventual increased volume of sales, prices
30 could be lowered. It turned out that this gamble was



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2 justified, so that by 1953, in the face of intensive
3 price competition from the other producers, the suggested
4 list price in Canada had dropped to \$9.35 for a bottle
5 of 16 capsules - 65% off the initial price. Further-
6 more, as an element in price reduction, the average
7 prescribed dose was changed in 1952 from 2 grams per
8 day to 1 gram per day. This was through increasing
9 knowledge of the action of the drug.

10 THE CHAIRMAN: You don't mean it was
11 only half as effective?

12 MR. THOMPSON: No, it was found with
13 broadening use that the lower dose could be used to
14 treat the patient.

15 THE CHAIRMAN: And get the same result?

16 MR. THOMPSON: Yes.

17 THE CHAIRMAN: Is that due to a longer
18 action -- had you developed a longer acting tablet?
19 Longer to be absorbed into the system?

20 MR. THOMPSON: No, this was new know-
21 ledge about the quantity needed. In the early stages
22 more was being used than was necessary, and when it was
23 discovered that a one-gram dose would be adequate for
24 the average patient, we promptly promoted it on that
25 basis.

26 THE CHAIRMAN: And the one-gram instead
27 of two-grams per day meant some reduction in the cost?

28 MR. THOMPSON: It cost the cost of
29 treatment in half because the original dose had been two
30 grams per day.



1
2 THE CHAIRMAN: The material that goes
3 into it, into the total cost of the treatment?

4 MR. THOMPSON: No, I am sorry. The cost
5 of furnishing Aureomycin for the patient on the basis
6 of two grams per day dosage would be twice as high as
7 the cost of furnishing the same drug on the one-gram
8 basis. You would use half as much drug.

9 THE CHAIRMAN: That means then by this
10 one change from two grams to one gram per day, the price
11 to the patient was cut in half by that one change?

12 MR. THOMPSON: Yes, the patient needed
13 half as many capsules.

14 Aureomycin, however, had certain drawbacks.
15 Unless substantial dosages were administered to the
16 patient at frequent intervals, the activity of the drug
17 would decline too rapidly in the body to deliver its
18 optimum effect. The larger the dosages, on the other
19 hand, the greater the risk of toxicity to the patient.

20 Faced with these problems, and with
21 severe competition from other broad spectrum antibiotics,
22 American Cyanamid in 1953 developed a superior broad
23 spectrum antibiotic, more stable and less toxic than
24 Aureomycin - namely, Achromycin, tetracycline. It was
25 more effective in penetrating certain critical body
26 tissues and fluids, such as those of the brain and spinal
27 cord, which made it the drug of choice in the treatment
28 of meningitis.

29 Achromycin was considerably more expensive
30 to make than Aureomycin. Introduction of the new product



1

2 to the medical profession required very heavy promotion-
3 al expenditures which would have justified a price far
4 higher than its predecessor. Pricing policy had to take
5 into account the fact that although the drug could have
6 been introduced at a far higher price, its acceptance
7 in that event would have been consequently delayed. It
8 was introduced in Canada in February, 1954, under the
9 trade name Achromycin at exactly the same suggested list
10 price for a comparable quantity as Aureomycin: \$9.35.

11 MR. WHITELEY: What would be the element
12 of the very heavy promotional expenditures?

13 MR. THOMPSON: Here was a new drug,
14 Mr. Whiteley, offered to the medical profession in the
15 face of an already widely accepted and trusted antibiotic,
16 and the burden was on our company to show that the new
17 Achromycin had sufficient advantages over Aureomycin
18 to justify a replacement in the mind of the physician.
19 This is a costly and difficult method or form of pro-
20 motion because physicians generally are very reluctant
21 to abandon something that works well for them.

22 MR. WHITELEY: I wondered how you
23 would proceed in that case?

24 MR. THOMPSON: We offered samples on a
25 broad scale, hoping the physician would try the new
26 drug and compare it with others he had used, including
27 Aureomycin. We sent salesmen to see the doctors with
28 visual material; we used direct mail advertising and
29 extensive journal advertising.

30

THE CHAIRMAN: I wonder, Mr. Thompson,



1
2 how the company could take a gamble on that scale unless
3 they were confident of what would happen in time. It
4 was more expensive to produce Aureomycin, and Aureomycin
5 came on the market at \$21.40, and this came on the
6 market at \$9.35.

7 MR. THOMPSON: The cost of producing
8 Aureomycin had dropped in the meantime.

9 THE CHAIRMAN: Oh, yes, for it would
10 cost more to produce Achromycin?

11 MR. THOMPSON: Yes.

12 THE CHAIRMAN: Considerably more, and
13 I would have thought that you would have to charge a
14 higher price when you had a heavy promotional programme
15 just as you had with Aureomycin.

16 MR. THOMPSON: I think I have to answer
17 your question in two parts. Achromycin is produced by
18 chemical alteration of Aureomycin, so that the reduced
19 cost of Aureomycin would form a base. The economy in
20 the Aureomycin process benefited Achromycin right from
21 the beginning, and the alteration of Aureomycin would
22 represent the extra cost in making the Achromycin over
23 Aureomycin.

24 THE CHAIRMAN: What I am getting at in
25 making your Achromycin, you start with the initial
26 cost of Aureomycin, and then you have a further process?

27 MR. THOMPSON: Yes.

28 THE CHAIRMAN: Which adds to that cost,
29 and then you add a very heavy promotional programme
30 which you probably didn't need at that time for



1
2 Aureomycin.

3 MR. THOMPSON: No, we transferred any
4 money that would have been spent on promoting Aureomycin
5 to Achromycin, so that in a sense Aureomycin helped to
6 carry the launching of Achromycin. It is quite custo-
7 mary in these situations to lose money on a drug at
8 first.

9 THE CHAIRMAN: I should think on those
10 prices you would be losing quite a bit.

11 MR. THOMPSON: Indeed we did.

12 THE CHAIRMAN: With Achromycin compared
13 to what your experience had been with Aureomycin. Mr.
14 Thompson, when you come to a convenient stopping point,
15 we will adjourn for lunch.

16 MR. THOMPSON: Mr. Chairman, would you
17 like to stop now? There are several pages to the
18 beginning of the next chapter.

19 THE CHAIRMAN: I think perhaps we had
20 better.

21 DR. R. G. WARMINTON: Mr. Chairman,
22 could I make a remark about the Achromycin dosage?
23 I was not too sure you understood as to why that was
24 reduced from two grams to one gram.

25 MR. THOMPSON: Aureomycin.

26 DR. WARMINTON: Aureomycin. The reason
27 of course is clinical files continue, and there are
28 specific projects set up to continue study of these
29 various compounds on well-established trials, and over
30 a period of time, although it appeared first of all that



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original dosage was the correct one, in light of further evidence it was discovered that it could be reduced satisfactorily to one gram per day.

THE CHAIRMAN: We will adjourn, ladies and gentlemen, and we will resume at 2 o'clock.

--- Luncheon adjournment.



.../dpw

1 --- On resuming at 2.10 p.m.

2 THE CHAIRMAN: The hearing is resumed ladies
3 and gentlemen.

4 MR. THOMPSON: Mr. Chairman, we have talked
5 about the introduction of Achromycin into Canada. I am
6 now continuing.

7 Unknown to Cyanamid, Pfizer and Bristol had
8 each independently been working on the development of
9 tetracycline. Within less than a year, Squibb and Upjohn
10 were also selling this drug in the market, and Cyanamid
11 thereby became one of five companies marketing it in North
12 America instead of being its sole seller.

13 THE CHAIRMAN: Mr. Thompson does that mean
14 that they all produce actually the same thing?

15 MR. THOMPSON: Yes Mr. Chairman. These
16 companies were apparently also interested in the same line
17 of research.

18 THE CHAIRMAN: Is it a refinement of chlor-
19 tetracycline?

20 MR. THOMPSON: Correct.

21 THE CHAIRMAN: And they work on the same
22 refinement?

23 MR. THOMPSON: That often happens, it opens
24 up a field of research based on the structure and the
25 various possibilities for altering it to improve the drug
26 action were all being considered simultaneously by these
27 companies and the one that emerged was tetracycline.

28 THE CHAIRMAN: And it was the same for each
29 company?

30 MR. THOMPSON: It was indeed, yes.



1 THE CHAIRMAN: They arrived at the same
2 improvement?

3 MR. THOMPSON: Yes. That led to this next
4 step that I was going to talk about now.

5 The latest chapter in Lederle's antibiotics
6 research is the development of an entirely new antibiotic,
7 superior in several respects to any previous broad spec-
8 trum. This was introduced in Canada in October of 1959,
9 as Declomycin demethylchlortetracycline. In brief, the
10 story of Declomycin is as follows: early in 1953, Cyana-
11 mid's biochemists, micro-biologists, cytologists, and
12 enzymologists had produced a biological mutant of the
13 Aureomycin-producing micro-organism discovered by Dr.
14 Benjamin Duggar of American Cyanamid in 1946. This mutant
15 had the unusual property of producing on fermentation a
16 very active antibiotic which had remarkable stability in
17 the human body. It took American Cyanamid's analytical
18 chemists almost two years to determine the chemical struc-
19 ture of this compound, which was like Aureomycin except for
20 the absence of a methyl group.

21 Cyanamid's pharmacologists then began a
22 series of tests, which took four years to complete, to
23 determine the toxicity and effects of the drug. Eventual
24 trials on human beings finally revealed no ill effects,
25 and indicated that as long as a week after administration
26 the drug proved to continue to have antibiotic activity.

27 Then Declomycin was sent out for clinical
28 testing by doctors outside the company. The report of
29 Dr. Maxwell Finland of the Harvard Medical School and of
30 the Thorndike Memorial Laboratory was typical. He wrote



1 to the effect that the drug should prove to be superior
2 to tetracycline in the treatment of susceptible infections,
3 in that comparable antibacterial effects should be
4 obtainable with small doses. A great deal of further
5 clinical testing on over 15,000 patients showed that the
6 drug was effective against more than 150 different
7 disease conditions. In most instances it has proved more
8 effective in smaller doses than older broad spectrums in
9 larger doses, and some infections which had resisted the
10 older drugs succumbed to this new one. The drug is a
11 superior antibiotic and costs considerably more to make
12 than Aureomycin or even Achromycin tetracycline a conside-
13 ration which would have justified its introduction to the
14 market at a far higher price than Achromycin. It was
15 decided, however, to introduce the product at exactly the
16 same price.

17 On page 173 of the Director's Statement,
18 comparative prices of broad spectrum antibiotics are
19 set out, showing that the major companies sell some of
20 their products at closely similar if not identical prices.
21 When there is vigorous competition between articles perfor-
22 ming the same function, it is not unusual to find similar
23 prices. This economic truth is being recognized by
24 leading economists including Dr. Simon Whitney, chief
25 economist of the U.S. Federal Trade Commission, who summed
26 up the reasoning that leads to price uniformity amongst
27 vigorous competitors in his work on antitrust policies,
28 at page 417:

29 "Sheer self-interest of each seller acting
30 independently can create price uniformity



1 since each knows that if he charges more than
2 the others, his sales will drop towards zero
3 and if he charges less than his rivals they
4 will be forced to meet his price".

5 The Director goes on, at page 174, to recapitulate the
6 price history of the broad spectrums. The story told
7 there is one of intense competition between the manufac-
8 turers. After four reductions from 1948 to 1951, the
9 published prices of antibiotics dropped to one-third of
10 the initial price.

11 The implication is frequently made that
12 equality of pricing is a prima facie sign of the existence
13 of monopolistic situations. But unless identical or equi-
14 valent products are offered at the same price, the over-
15 priced product cannot be competitively sold. Furthermore,
16 as the Director himself point out at page 174, the price
17 history of the broad spectrums reflects intense competition
18 among the manufacturers.

19 As an illustration of this, consider the
20 history of tetracycline price reductions in Canada during
21 the last quarter of 1960. On Saturday, October 22nd we
22 released a notification to the drug trade that effective
23 Monday, October 24th the prices of our broad spectrum
24 antibiotic line were being reduced by approximately 15%.
25 On Tuesday, October 25th, one of our major competitors
26 (Squibb) announced a similar reduction of their competitive
27 line to hospitals. On October 27th, another competitor
28 (Pfizer) reduced its hospital price, and followed on
29 October 31st with a price reduction to the retail drug
30 trade.



1 Due to differentials in methods of marketing,
2 we quickly found ourselves at a 10% price disadvantage to
3 hospitals and on November 7th issued a price reduction
4 notice reducing our hospital prices to the new competitive
5 level. The remaining major competitor (Bristol) met the
6 new hospital price on November 10th.

7 Thus, within a period of three weeks, all
8 the major suppliers of tetracyclines in Canada revised
9 their price schedules to meet the new market prices
10 established by our original price reduction, and we
11 ourselves were forced by competition to issue a second
12 price reduction to eliminate a competitive price disadvan-
13 tage in the hospital market.

14 The Director in his Statement, at page 163
15 states - "present prices of both the basic drug and
16 prepared dosage forms (of penicillin) appear to result
17 from the absence of patent control which has meant that
18 the drug has been freely available to all firms wishing to
19 deal in it". This observation fails to take account of the
20 fact that the potentiality for reducing costs through
21 improved technology in the case of penicillin has already
22 been incorporated into the production of the broad spec-
23 trums before they reached the market. Also, the drop in
24 prices of broad spectrum antibiotics could never be as
25 dramatic as in the case of penicillin, which originally
26 sold for \$6,000 per gram.

27 The prices of penicillins reached such a low
28 level, due to wide overproduction resulting from the crea-
29 tion of wartime capacities, that it was impossible to make
30 a profit on them, and several drug companies were forced



1 out of the penicillin business. This condition was recog-
2 nized in the U.S. in the Federal Trade Commission Economic
3 Report on Antibiotics Manufacture, which discloses that
4 from 1951 through 1956 the drug industry lost large amounts
5 of money every year on the penicillins and streptomycins
6 (Table 58, page 211). Of the 20 companies in the United
7 States originally engaged in the manufacture of penicillin
8 during World War II, nine (or almost 50%) went out of busi-
9 ness. The Commission even expressed its wonderment that
10 certain companies continued to manufacture streptomycin in
11 the face of increasing losses on this product.

12 The situation was dramatically reflected in
13 Canada in very much the same way. The Merck Company
14 erected a plant in Valleyfield, Quebec, to produce peni-
15 cillin. For the reasons recited above, this company found
16 it necessary to close down its \$1,000,000 plant and to
17 discontinue the production of penicillins, with the resul-
18 ting lay off of several hundred Canadian employees.

19 I might add, Mr. Chairman, that a similar
20 situation arose in the case of the Connaught Laboratories
21 who, according to testimony of Dr. Ferguson before the
22 Ontario Select Committee closed down their plant in 1956
23 due to over-production.

24 Now I would like to switch to the question
25 of patents and research.

26 PATENTS AND RESEARCH

27 To say that the drug trade in Canada in
28 effect operates under the U.S. patent system (Statement,
29 page 247, para. 441) is simply not the case. The fact is
30 that Canadian patent law differs markedly from the American



1 law. In the first place, the way is open to anyone capable
2 of manufacturing drugs in Canada to apply for and obtain a
3 compulsory licence to manufacture any drug which is the
4 subject of a Canadian patent. This fact is consistently
5 and repeatedly overlooked by the critics of the industry,
6 who have before this Commission repeated ad nauseam that
7 the Canadian patent law is responsible for the high cost
8 of drugs.

9 In the second place, Canada recognizes
10 generally, only process patents (not product patents), so
11 that drugs may legally be manufactured or imported, and
12 sold in Canada, when they have been manufactured by a
13 process different from that which is the subject of the
14 Canadian patent. This is precisely what is being done in
15 Canada today. Quite a large number of importers are
16 marketing drugs in Canada which may or may not be infringe-
17 ments of Canadian patents, and they pay no royalties.
18 These people are being encouraged by the purchasing agencies
19 of the government, hospitals and others who buy from them.

20 THE CHAIRMAN: Mr. Thompson that would suggest
21 there might be a great deal of difficulty in finding
22 whether they are infringing the Canadian patents. Is
23 that the case?

24 MR. THOMPSON: Yes Mr. Chairman. This can
25 be exceedingly difficult. Only in limited situations can
26 we determine by analysis the process by which a drug has
27 been produced. More frequently it is impossible to tell.

28 THE CHAIRMAN: Unless you had access to
29 their plants, I suppose you ---

30 MR. THOMPSON: Yes.



1 THE CHAIRMAN: --- find it very, very diffi-
2 cult.

3 MR. THOMPSON: And it is difficult, for
4 example, when the infringed product is originating behind
5 the Iron Curtain.

6 THE CHAIRMAN: Is that true of many drugs?

7 MR. THOMPSON: Well I don't think I am
8 competent to answer that on a broad basis. Some tetra-
9 cycline is coming from Czechoslovakia, for example.

10 THE CHAIRMAN: Most of the drugs we have
11 heard of, apart from those produced on this continent,
12 have been from England, France, Germany, Switzerland or
13 Italy, Scandinavia.

14 MR. THOMPSON: Some drugs originated in
15 Japan and the other low countries in Europe, Denmark, and
16 so on.

17 THE CHAIRMAN: As far as our records go, I
18 don't think we have anything that amounts to anything from
19 behind the Iron Curtain.

20 MR. THOMPSON: It appears to be a recent
21 development.

22 We wish to examine in some detail the views
23 of the Director that patents closely held and controlled
24 by leaders in the drug industry result in monopolistic
25 situations whereby the prices of drugs are maintained at a
26 high level and whereby competition is minimized. A monopo-
27 list is one who is relatively immune from competition.
28 But, no patent holder in the drug industry is immune from
29 competition from
30



'PB/md

1 directly competing products, and he cannot therefore
2 control the prices of his drugs. It is true that
3 American Cyanamid held exclusive rights under a patent
4 on Aureomycin chlortetracycline, and so for one year it
5 had a legal monopoly on broad spectrum antibiotics, since
6 there were no others in existence during that period.
7 But this very monopoly, with its prospect of financial
8 reward, spurs competitors produce comparable or
9 better products. This is exactly what happened in the
10 case of Aureomycin, as we have said, which was closely
11 followed by Parke-Davis's competing Chloromycetin,
12 thereby nullifying any monopoly existing by way of the
13 Aureomycin patent.

14 The contention that patents are largely
15 responsible for high prices is simply not correct. On
16 this point, reference is made to the following remarks
17 of the Commissioner of Patents, Mr. Michel, to this
18 Commission on July 5, 1961. He said:

19 " In my opinion the patent system,
20 if it is a factor in the high price of
21 drugs, it certainly is not the main factor".

22 THE CHAIRMAN: You are referring to
23 Aureomycin and chlortetracycline and mentioning that the
24 second one nullified the monopoly existing by the
25 Aureomycin patent. Would you say there were, to all
26 intents and purposes, identical products?

27 MR. THOMPSON: Chemically different,
28 produce different side effects but they are used generally
29 for the same diseases.

30 THE CHAIRMAN: They work on the same



1 conditions?

2 MR. THOMPSON: Yes.

3 THE CHAIRMAN: And in a very similar
4 way apart from differences in side effects?

5 MR. THOMPSON: They are both broad
6 spectrum antibiotics. They have similar

7 DR. WARMINTON: To all intents and
8 purposes they have a similar range of activity. There
9 are some differences, some things are better attacked.
10 The tetracyclines don't have the same effect that
11 chloramphenicols have, but to all intents and purposes
12 they are both broad spectrum antibiotics.

13 THE CHAIRMAN: I think we had better,
14 for the record, get a definition of wide spectrum
15 antibiotics.

16 DR. WARMINTON: The wide spectrum anti-
17 biotics refer to those compounds which will attack a
18 wide range of bacteria of various kinds.

19 THE CHAIRMAN: That is what I thought.
20 I wanted to be sure it is on the record.

21 MR. THOMPSON: We have found in our
22 market activities, it is frequently found doctors have
23 difficulty choosing between chloramphenicol and the
24 tetracyclines. There are many situations, it is a
25 marginal choice. They are very competitive for that
26 reason.

27 THE CHAIRMAN: I am sorry, I interrupted
28 you.

29 MR. THOMPSON: I think I had just
30 quoted Mr. Michel.



1 This is the very reason why the compulsory licencing
2 features of the Canadian Patent Act have not been utili-
3 zed more than they have been. The truth is that, if a
4 small manufacturer wishes to produce and market under a
5 compulsory licence, an antibiotic such as one of ours
6 patented in Canada, and to sell that drug which is
7 already being marketed nationally in Canada, the manu-
8 facturer would first of all have to have production
9 facilities that would cost him probably in the region of
10 \$1,000,000. He would then have to have skills and
11 organization necessary to develop and market his product
12 in competition with the established manufacturer.
13 He would be merely imitating, he wouldn't be adding
14 anything new.

15 Further, it would take him at least a
16 year to obtain the requisite quantity and quality of
17 product, from his plant, and by that time his product
18 might be obsolete. Some have asserted that it is very
19 easy to make and sell these drugs. Our only reply is
20 that we have not found it so, and we have been in the
21 business for a long time.

22 THE CHAIRMAN: This question occurs:
23 you have a number of companies which have the equipment
24 for producing antibiotics and if one company produces a
25 new drug another company which had the equipment wouldn't
26 incur this million dollar expenditure to start making
27 this new drug if they had a licence, would they? It
28 would just be a case -- it wouldn't be like starting
29 from the position of having no facilities to make
30 antibiotics?



1 MR. THOMPSON: The facilities are quite
2 different.

3 THE CHAIRMAN: For each drug?

4 MR. THOMPSON: Yes, for example, the
5 separating of crude drug out of reaction amongst
6 fermentation vary widely according to the nature of the
7 centrifugal equipment, extractors, filters. It is
8 quite different. We are just in the process of purchasing
9 for our new Welland plant, and as far as we know there
10 is nothing quite like it, nothing suitable in Canada
11 at the present time.

12 THE CHAIRMAN: What I want to get clear,
13 does your presentation mean whatever the company,
14 including established companies like yourselves, whenever
15 they wish to produce a new antibiotic for which they
16 have the formula and all the rest of it, they would have
17 to incur the expense of something in the neighbourhood
18 of a million dollars to start it up?

19 MR. THOMPSON: I would guess it. I am
20 using the one subject I know a little about as an example.
21 I don't mean to infer that it is always true, for example,
22 Chloramphenicol, which is now being made in Canada
23 synthetically, rather than by fermentation, presumably
24 didn't require this much investment. It depends on
25 the nature of the drug, but in many cases these new
26 drugs are complex and becoming increasingly so, and the
27 equipment is specialized.

28 THE CHAIRMAN: I want to be sure it
29 really meant a company producing five or six different
30 antibiotics would have to have a completely different



1 setup costing a million dollars on the average to
2 produce each one of these?

3 MR. THOMPSON: That is certainly true
4 for a company that is making penicillin and wishes to
5 add the tetracyclines. I don't think I know enough
6 about these things to go beyond that kind of answer.
7 There is another reason why. This is not just the
8 investment. I have another reason I will come to now.

9 THE CHAIRMAN: You may have several more.

10 MR. THOMPSON: The reason why big
11 companies who already have production facilities do not
12 get compulsory licences to make drugs, I am talking about
13 drugs generally now, is that their production and
14 marketing costs would be the same as those of the patentee
15 who has the advantage of being more strongly established
16 in the market and in a superior competitive position.

17 THE CHAIRMAN: Without the basic research,
18 I suppose?

19 MR. THOMPSON: Yes, but I am seeking
20 here to express the difficulty of entering a market which
21 is already well developed and simply competing with a
22 company who is already there.

23 THE CHAIRMAN: That is the competitive
24 problem of selling in an already established market?

25 MR. THOMPSON: Yes.

26 The larger company would far rather develop
27 its own product than go into the market with someone
28 else's product. Cyanamid, for example, could undoubtedly
29 obtain a compulsory licence on a number of patent
30 protected products. But in order to take business away



1 from the patentee, we would have to detail the product
2 to doctors, this is not easy when the products are
3 identical or very similar, and we would have to pay a
4 royalty. We are in a far better position with our own
5 product. It is simply not profitable to market a
6 product developed by a competitor who has fully estab-
7 lished himself in that market.

8 We doubt that an informed critic of the
9 industry would advocate the abolition of the patent
10 system. Mr. Michel, in his testimony before this
11 Commission, it will be recalled, had the following ob-
12 servations to make:

13 "Research in the medical and drug field
14 is carried on to a considerable extent
15 abroad, although I am pleased to point
16 out there is a sizeable amount of it done
17 in Canada by our own governments, by
18 universities and by a section of the
19 pharmaceutical industry. I am wondering
20 if too drastic a treatment of the patent
21 system would not harm the modest, but bona
22 fide, efforts of those doing research in
23 Canada more than the quota of the high
24 price of drugs which might be attributed
25 to the patent system. After all our
26 pharmaceutical manufacturing industry is
27 still small, but so were most of our
28 industries not so many years ago."

29 It is this research effort that Mr. Michel talks about
30 which we believe is vital to the drug industry and which



1 would be seriously jeopardized if there were no patent
2 protection for the inventor and his company.

3 The Canadian consumer purchasing drugs
4 manufactured by a Canadian subsidiary of an American
5 parent company finds that he is contributing to the cost
6 of research whether that research is carried on in Canada
7 or in the United States. In the present state of deve-
8 lopment in Canada, as has been pointed out, it is more
9 economical at the present time that Cyanamid research
10 be carried on at the already existing facilities of the
11 parent company.

12 We have no doubt, Mr. Chairman, that as
13 the Canadian pharmaceutical industry expands, so will
14 research activities expand. This is certainly our
15 expectation at our own manufacturing centres in Canada,
16 especially when we are engaged in a full scale manufac-
17 ture of broad spectrum antibiotics. American Cyanamid
18 Company has indicated its willingness to decentralize
19 its basic research activities. An example of such
20 decentralization is the Geneva Research Laboratory main-
21 tained in Switzerland by American Cyanamid. As research
22 efforts in the industry become increasingly directed
23 toward fundamental research, it becomes increasingly
24 possible to decentralize.

25 In addition, it is necessary to invest in
26 facilities such as those to be found at the Geneva Re-
27 search Laboratory. Furthermore, talented and trained
28 scientists are in short supply, and it is becoming in-
29 creasingly necessary for the mountain to go to Mohammed.
30 It is to be noted that the U.S. people think very highly



1 of Canadian technical and scientific talent. I might
2 add there are five Canadians employed in our Lederele
3 research unit at Crow River, New York. But as has been
4 pointed out already, the products of Canadian universities
5 are all too prone to seek employment elsewhere. American
6 Cyanamid recently employed a Swiss national, Dr. E.
7 Moser, who had been living in Canada but who chose to
8 return to Switzerland. The Company invested more than
9 \$100,000 in facilities and equipment for the benefit of
10 Dr. Moser, a further indication of American Cyanamid's
11 willingness to decentralize its activities in the
12 research field if a conducive atmosphere exists.

13 There are, however, obstacles to be over-
14 come before commercial research can be embarked upon to
15 any marked extent in Canada. The following observations
16 of Mr. Andre Forget, in his address to the Canadian
17 Pharmaceutical Manufacturers Association, already alluded
18 to, express our own feelings in the matter. He said:

19 "Very little pharmaceutical research is
20 being carried out in Canada at the moment.
21 This is unfortunate. Some of the Canadian
22 firms should put more money in research
23 and our friends from other countries who
24 have establishments here should be invited
25 to dedicate part of their Canadian plants
26 to research. It is an often-voiced complaint
27 that Canadian scientists go abroad as
28 they cannot find suitable opportunities in
29 this country. A greater number of pharma-
30 ceutical research establishments in Canada



1 would tend to alleviate the situation. At
2 present, Canadian universities are train-
3 ing scientists at great cost for the
4 benefit of foreign countries. But in order
5 to achieve this aim Canadian legislation,
6 including the Patent Act, must provide
7 propitious conditions, a propitious
8 climate. If the firms investing money in
9 this country in research cannot be certain
10 that they will enjoy the fruits of their
11 research, but that these will immediately
12 be appropriated by their competitors on
13 nominal terms, then very little incentive
14 is left for them to organize research
15 facilities in Canada. The alternative to
16 which I alluded above would be to get a
17 "free ride" on everybody else's research
18 as is the situation in Italy at the
19 moment. To my mind, such a policy verges
20 on what may be termed political immorality,
21 as Canada would then be participating in
22 the benefits of research without sharing
23 the costs."

24 But, as Mr. Forget indicates elsewhere in his talk, we
25 do not feel the the Canadian Patent Act should be ex-
26 tended to permit compulsory licencing as a matter of
27 right, and that any such extension would seriously deter
28 the expansion of drug research in Canada. The only
29 changes in the Patent Act which we would favour at the
30 present time would be to support the recommendations of



1 the Ilsley Commission that patent protection in respect
2 of food and drugs be extended to include products as
3 well as processes.

4 THE CHAIRMAN: In regard to that don't
5 you think the Canadian Patent should be a compulsory
6 licence as a the matter of right, not directly a matter of
7 right as we understand it, but we were told in Ottawa
8 if the applicant was to apply to produce a drug they
9 get the licence if they show they are willing and able.

10 MR. THOMPSON: Yes. Well, my under-
11 standing is that an applicant must demonstrate his
12 ability and as the holder of the patent his right to be
13 heard, and as I understand the Commissioner grants the
14 licence unless he sees reason to the contrary.

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1 C/JW/hm

1 THE CHAIRMAN: They don't get it actually
2 as a matter of right, but as I understand, as it was given
3 to us, it was simply if they have the facilities.

4 MR. HALL: I wonder if I might qualify
5 with an observation in regard to discussions and
6 recommendations which have been made --

7 THE CHAIRMAN: You are Mr. Hall?

8 MR. HALL: That is correct. For instance
9 it was discussed in the Ilsley Commission that amendments
10 to the Patent Act might include commissions for the
11 granting of compulsory licences as a right. The commission
12 then decided that it would not make such a recommendation
13 itself, but recommendations have been made that the Patent
14 Act might be extended or improved to include such a
15 provision. With respect to these suggestions, they would
16 not be in favour of such a recommendation.

17 THE CHAIRMAN: I understand that, but I
18 want to get clear whether we have the picture correctly
19 from the Food and Drug branch, of the Commissioner of
20 Patents, that it was not difficult to get a compulsory
21 licence if you had the facilities to produce. You do not
22 get it as a matter of right, and other people have the
23 right to object to it and they have trouble convincing
24 them they should have a compulsory licence.

25 MR. THOMPSON: That is right. I have a
26 few conclusions, Mr. Chairman and then I will be through.

27 Cyanamid's Canadian business has formed
28 part of the North American business of the Cyanamid group.
29 This relationship has brought many advantages to Canada,
30 including particularly the benefits of American research



1 and experience resulting in the rapid introduction of new
2 and tested drugs to the Canadian market.

3 This was a natural and logical development
4 and now, with the gradual development of the Canadian
5 market and the development of managerial and technical
6 skills in Canada, the next natural step is the extended
7 Canadianization of the operations of Cyanamid in Canada.
8 Plans are now well advanced for the development of a
9 complete manufacturing operation.

10 It is stated on page 115 of the Statement
11 that the large ethical drug firms spend proportionately
12 more than do small firms on advertising. We suggest that
13 there is a good reason for this, namely, that large
14 companies usually are those with original products. It is
15 these products which require the greatest effective communica-
16 tion with the medical profession and the drug trade.

17 We would like to see this process become
18 much more efficient, and thus reduce the burden of marketing
19 costs. In this regard, we would be in favour of an
20 official bulletin or other regular publication designed to
21 acquaint doctors and hospitals and drug purchasing agencies
22 with information on the latest developments in the drug
23 industry. We feel that such a publication is, in fact, long
24 overdue and we would be prepared to give active support to
25 its publication.

26 We have made some preliminary investigations
27 along this line and we have received encouraging expressions
28 of support from members of the medical profession and the
29 industry itself. We feel that in order to be sufficiently
30 authoritative, the publication would have to bear the stamp



1 of approval of the medical profession, preferably of the
2 Canadian Medical Association, as well as the government.
3 In this regard the Food and Drug Directorate has already
4 facilities at its disposal to enable it to contribute
5 substantially to the formation of an organization to
6 publish this type of review. We feel that the major
7 ethical manufacturers would be more than happy to submit
8 materials and results of clinical investigations to the
9 publication.

10 Should this step prove successful, this
11 co-operative organization could possibly extend its
12 activities to a wider field including the review of product
13 claims, the establishment of improved standards of purity
14 and quality, reports on clinical tests and other matters
15 of interest to the industry.

16 Thank you very much.

17 MR. WAHN: Mr. Chairman, arising out of
18 Mr. Thompson's evidence I have three or four specific
19 questions to ask if this would be the appropriate time.

20 THE CHAIRMAN: I was going to ask a question
21 about this recommendation, to see where it might lead.

22 Mr. Thompson, I gather glancing through this
23 as you are reading it, that you have in mind a publication
24 to be published officially by the government, but with
25 assistance from the Canadian Medical Association and possibly
26 some of the drug companies.

27 MR. THOMPSON: We did not form the definite
28 opinion as to who should publish it, but we do feel that
29 the voices of the government, the Medical Association, and
30 the manufacturer would have to be heard.



The manufacturer, after all, generally is the person who knows more about his drug than anyone else, and he is in a position to supply information that would otherwise be difficult to gather. But it is a difficult and expensive business to transmit the significance of that information to the physician in a manner which gains his confidence and this burden falls more heavily on the part of the company with research facilities than it does on any other. My opinion is that if the information which the physician needs were officially sponsored by his own medical group with the assistance of the government, that it would be much less costly, and my feeling is that there should be a small group formed with the participation of government and the Medical Association and the manufacturers to consider how this best might be accomplished. Whether it should be a government publication or a Medical Association publication, I think is debatable.

THE CHAIRMAN: I gather you have not pursued it far enough to express any considered opinion as to what might be involved in the way of staff and costs and that sort of thing, because it might be a pretty big undertaking.

MR. THOMPSON: The information that such a publication would carry is already available. It is coming available routinely through the manufacturers, and it would just be a matter of getting it into a concise form and giving it the official sponsorship that I have suggested.

THE CHAIRMAN: It would mean a great deal



1 of checking by other people than the company producing it.
2 They are going to give it their official stamp, and they
3 would not take it just as it comes.

4 MR. THOMPSON: I would hope they would ask
5 for evidence to support their claims.

6 THE CHAIRMAN: It would not be very useful
7 unless they did.

8 MR. THOMPSON: No, we would hope for it to
9 be checked, but much of the checking and much of the
10 evidence in support of claims could be furnished by the
11 company. I think we would find this rather easy.

12 THE CHAIRMAN: What would you anticipate was
13 the net result? Would it enable you to reduce to some
14 extent your cost of promotion?

15 MR. THOMPSON: Yes, I think it would.

16 THE CHAIRMAN: Do you think it would be
17 significant?

18 MR. THOMPSON: I think physicians would be
19 more inclined to believe and accept information which
20 reaches them under such official sponsorship, and that the
21 rather expensive business of visiting a physician and
22 interviewing him with a trained representative, and answer-
23 ing his questions, and so on, that the need for this would
24 be reduced.

25 THE CHAIRMAN: And I suppose that would
26 include advertising documents that would be sent around to
27 him and so on?

28 MR. THOMPSON: That would be the objective,
29 the total marketing effort.

30 THE CHAIRMAN: Do you anticipate there might



1 be some quite significant savings?

2 MR. THOMPSON: It is a little hard to say.

3 THE CHAIRMAN: It is hard to press for an
4 opinion. I am just trying to see how far you have gone
5 with it.

6 MR. THOMPSON: I have not gone very far.
7 I think the concept is sound and I hope it would be
8 pursued, and I think there ought to be very noticeable
9 savings.

10 MR. WAHN: Mr. Thompson, questions have
11 been raised as to the actual value of certain of the
12 expenditures made by manufacturers in promoting the sale
13 of prescription drugs. In your evidence you have indicated
14 quite clearly that the companies consider that such
15 expenditures are absolutely necessary in order that they
16 may stay in business and compete with other companies who
17 are making such expenditures.

18 Is there any evidence that these promotional
19 expenditures that you have discussed are also of some
20 social value in promoting the sale and greater knowledge
21 of worthwhile prescription drugs? Could you give the
22 Commission any evidence along those lines?

23 MR. THOMPSON: Yes, I think so, very
24 definitely. The concept of prescribing by a generic name
25 as a means of obtaining medication at a lower cost is
26 simply a device for rendering the manufacturer unable to
27 afford to promote his product or to do the research which
28 makes it possible.

29 I understand that there is a law now under
30 consideration in Alberta -- and Mr. Frawley may care to



1 comment on this -- which would permit the pharmacist to
2 substitute a product in his opinion equivalent without
3 consulting the physician. The effect of this and the
4 effect of buying competitively by tender is that it becomes
5 increasingly unattractive for a manufacturer to take the
6 risk of promoting a new drug because if he promotes it,
7 he is merely creating a market for someone else, and that
8 is a very good way for him to go broke.

9 As a matter of fact, I have got an example
10 that I think might be appropriate. This is a bottle of
11 tablets of calcium carbimide which is a chemical substance
12 that our company makes in large amounts. I think we made
13 something like 220,000 tons in crude form last year. This
14 drug is widely available and yet there is no demand. There
15 is virtually no demand for this substance.

16 MR. WHITELEY: How much, 220,000 tons?

17 MR. THOMPSON: Yes.

18 MR. WHITELEY: And there is no demand for
19 it?

20 MR. THOMPSON: As a drug. It is widely
21 used as a chemical raw material, as a fertilizer.

22 THE CHAIRMAN: It is a drug for the land,
23 is it?

24 MR. THOMPSON: We think it has value as a
25 drug for human beings and in that regard I would like to
26 read some comments that have been made by prominent
27 Canadian physicians about the substance. These were made
28 by Doctor S. E. C. Turvey of the staff of Internal Medicine
29 and Neurology, Vancouver General Hospital, and on the
30 Neurology Research Department of the University of British



1 Columbia Medical School. Doctor Turvey said in his
2 summary of a report:

3 "I do think you have a most unusual product
4 and for these reasons: (2) Useful in
5 practice, either with or without the patient's
6 knowledge".

7 Incidentally, that refers to the treatment of alcoholism.
8 The patient who takes these tablets finds it exceedingly
9 unattractive to drink an alcoholic beverage afterwards.
10 Doctor Turvey also says, "It is safe and harmless".

11 I have also some comments. These comments
12 were made in the Canadian Medical Association Journal a
13 couple of years ago by Dr. J. K. Ferguson.

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7D/EMI/hml 1 Dr. Ferguson was a Professor of Pharmacology, at the
2 University of Toronto, and is director of the Connaught
3 Medical Research Laboratories, University of Toronto. He
4 said "This study suggests that citrated calcium carbimide
5 is useful in the treatment of alcoholism". He further
6 says "It would also appear there are fewer side effects
7 with CCC, and that it may be a drug of choice."

8 THE CHAIRMAN: From my information there
9 is no demand for it.

10 MR. THOMPSON: I think this is rather
11 significant, Mr. Chairman. These are the reasons that we
12 believe this drug should be promoted. We believe that it
13 is safe; it is useful, and it works, and therefore it
14 is almost a moral obligation to bring it to the attention
15 of physicians.

16 THE CHAIRMAN: Does it have longlasting
17 results? A person takes that for a while and they are not
18 attracted to alcohol for the rest of their life?

19 MR. THOMPSON: No, during the period of
20 treatment it requires a dose of 2 tablets a day. One
21 tablet every twelve hours, and this provides continuous
22 protection.

23 I may say it is a drug which is useful
24 because of its side effects. Nothing happens unless one
25 takes an alcoholic beverage, and an unpleasant but not
26 dangerous reaction develops. Dr. Warminton, is there
27 anything you would like to say about that?

28 DR. WARMINTON: I think what Mr. Thompson
29 has explained is true. This has a side effect which was
30 observed on workers who got into concentration of this



1 material. They had a very unpleasant effect if within a
2 period of approximately 12 hours after exposure to the
3 material they took alcohol, and developed on that basis
4 is this tablet which is used as an adjunct. This is not
5 the type of thing one can say is a complete treatment.
6 It is used in conjunction with other treatment, but this
7 is something which will support patients and will give
8 them a good deal of support during the time other measures
9 are used to assist with the alcoholism problem.

10 MR. THOMPSON: Is it fair to say these
11 investigators have recommended that the drug be promoted?

12 DR. WARMINTON: Yes, they are highly in
13 favour of this because of its lack of toxic effect. Other
14 drugs for this same purpose have had some highly undesirable
15 toxic effects, and this one does not.

16 MR. THOMPSON: My point, Mr. Chairman, is
17 in spite of the various favourable recommendations that
18 we have had, the drug is not in general use because it has
19 not been generally promoted. I don't believe it will come
20 into use by itself. It lends itself to use by many
21 institutions, and for example, in Newfoundland a fair amount
22 is used. I notice that none was purchased in the last
23 year or the year before by your associates. Mr. Frawley,
24 in Alberta.

25 Now, our problem is it is going to cost a
26 considerable amount of money to promote the drug, and I
27 think we would be reluctant to promote it in an atmosphere
28 where we are merely creating a market for someone else. In
29 fact, I think you can see that no company can afford to
30 discover and launch a new drug if some imitator is going to



1 do all the business. I believe promotion is an absolutely
2 essential element, and I hope that my company will continue
3 to have a right to at least identify its own products so
4 that it has some hope of doing some of the business it
5 creates.

6 MR. WAHN: Another aspect of this prospect
7 of promotion is this: It has been suggested with
8 sufficiently large expenditures it is possible to effect
9 large sales of almost any prescription drug whether the
10 prescription drug has any value or not. Would you say
11 that, first of all, is this statement true, and if it is,
12 does it happen to any extent in the industry?

13 MR. THOMPSON: I think Mr. Antoft of the
14 Nordic Biochemicals made a statement to that effect, and
15 I would like to present this package as evidence this is
16 not true. This is a preparation called Cellothyl. This
17 product was introduced in Canada about 1950 as a totally
18 safe and harmless and yet effective laxative, as indeed
19 it was strongly recommended in a clinical study by Dr.
20 Arnold Bargain, the chief of the gastro-enterological
21 service at the Mayo Clinic, and there was every reason to
22 suspect that this would overcome most of the drawbacks of
23 irritant laxatives, which of course, come to be habit
24 forming.

25 This product was promoted intensively for
26 about four years with considerable expenditures behind it,
27 and at the beginning it enjoyed a good sales volume, but
28 later sales began to dwindle, and despite the best efforts
29 of not one company but several companies in the United
30 States, the Upjohn Company entered this market and put 750



1 salesmen to work on liquid form; the Eli Lilly Company
2 did the same thing, so there were three people all com-
3 peting for the business with the same drug.

4 THE CHAIRMAN: That is not a prescription
5 drug?

6 MR. THOMPSON: No. This drug was promoted
7 through physicians because it is right that physicians
8 should manage patients with severe constipation.

9 THE CHAIRMAN: Is it patented?

10 MR. THOMPSON: No.

11 THE CHAIRMAN: Anybody can get it?

12 MR. THOMPSON: Yes. Raw material is made
13 by the Dow Chemical Company, and it is used in food, in
14 the food industry, and many other uses on this list. Its
15 drug action was discovered later. There was no patent
16 protection of any kind, but the sales began to dwindle,
17 and now I would suspect many druggists in Canada have
18 forgotten its name. In fact it is rather significant this
19 bottle is half full and was never emptied because I got
20 this from a physician's office in Ontario, and it was
21 lying idle on the shelf for about five years, and yet this
22 is a safe substance, which works.

23 I am the person who introduced this in
24 Canada, Mr. Chairman, so I made the mistake. I believe
25 that the reason this drug failed is because it is too
26 difficult a burden for the physician to carry out the
27 supervision of his patient that this kind of product
28 requires. He would prefer to use a more active drug
29 requiring smaller dosage and acting more promptly even
30 though it may not be quite as safe.



1 THE CHAIRMAN: Does it require continued
2 supervision?

3 MR. THOMPSON: Yes, it takes about a week
4 for this to act. Nine tablets a day, and most patients
5 are not willing to wait that long. It is very difficult
6 to get the patient to co-operate. You have to continue
7 taking them.

8 THE CHAIRMAN: Nine per day right along?

9 MR. THOMPSON: Well, the recommendation
10 was that the dosage be reduced. It is not on the label,
11 but the literature recommended reduction of dosage.

12 THE CHAIRMAN: Various things have come on
13 the market for the same purpose in the last seven or
14 eight years.

15 MR. THOMPSON: Yes, one of our own products,
16 the Aerosol O.T. which is a Cyanamid chemical product,
17 produced as a detergent, as a wetting agent, is a very fine
18 laxative also. It was marketed aggressively by three
19 companies in Canada, Meade Johnson was one, and there were
20 a couple of others, and promoted exclusively, and it too
21 gradually dwindled, in spite of extensive promotion, and
22 I think for the same reason.

23 There is a boneyard which is full of
24 products like this that seem to have merit, but where the
25 manufacturer has either misjudged them, and there have been
26 efforts to promote products that have marginal benefits
27 in the belief that strong promotion would overcome the
28 marginal nature of the benefit, but this always failed.
29 I don't know anybody who has successfully fooled physicians
30 over any extended period of time with a drug.



1 THE CHAIRMAN: I hope they wouldn't be
2 able to fool them for too long.

3 MR. THOMPSON: Hexamethonium, this drug
4 failed because it was difficult to use. Hexamethonium
5 is very potent for hypotension, but it is a dangerous
6 drug, and I think physicians conclude that they would
7 rather use a less potent drug and take a little longer
8 to get control of their patient's blood pressure rather
9 than run risks of using a very dangerous substance, and it
10 is out of use now.

11 MR. WAHN: Your point being that promotion
12 itself is not sufficient to ensure extensive sales of
13 drugs?

14 MR. THOMPSON: Very definitely.

15 THE CHAIRMAN: The drug must have merit or
16 it won't continue in use?

17 MR. THOMPSON: Yes, indeed.

18 MR. WAHN: I believe statements have been
19 made, Mr. Thompson, to the effect -- and this is in
20 relation to the controversy between brand names and generic
21 names -- that manufacturers in Canada tend to over-
22 emphasize to the retail druggist the profit they can make
23 by selling brand name drugs, thus creating favouritism on
24 the part of druggists who use brand name drugs rather than
25 generic name drugs.

26 Would you care to comment on this suggestion?

27 MR. THOMPSON: I would indeed. I think
28 Mr. Antoft mentioned the March 1961 issue of the Canadian
29 Pharmaceutical Journal, and indicated in his testimony that
30 most of the advertising was oriented towards the profit the



1 pharmacist could make on ethical products.

2 I don't believe he read the journal
3 thoroughly, because this issue, and I would be glad to
4 leave it with the Commission, contains 14 advertisements
5 which mention the words "Profit" or "Dollars" or similar
6 expressions. Only four of those advertisements were
7 placed by ethical manufacturers, and out of those four,
8 three were for over-the-counter items. That is, items
9 which do not require prescriptions, where the druggist
10 can make the sale by his own effort.

11 All of the other profit-mentioning advertise-
12 ments were placed by proprietary houses or advertised
13 non-drug items. In other words, items which do not require
14 the intervention of a physician, so that I suggest it is
15 not customary or desirable or even effective for an ethical
16 pharmaceutical manufacturer to suggest to the pharmacist
17 "You can make more profit by selling my product than
18 somebody else's".

19 THE CHAIRMAN: That is the issue that Antoft
20 was referring to?

21 MR. THOMPSON: Yes.

22 THE CHAIRMAN: May I see that, please?
23 Exhibit T4.

24 MR. WAHN: In your evidence, Mr. Thompson,
25 you made a number of references to the extremely competitive
26 nature of the drug manufacturing industry with particular
27 reference to the field of antibiotics, and outlined in some
28 considerable detail the nature of competition in that
29 field between the various companies who produced products
30 which could serve much the same purpose.



1 My understanding is that your company has
2 published a card or informational bulletin with comparative
3 prices as between declomycin and certain of the other
4 competitive products.

5 MR. THOMPSON: Yes, we have repeatedly
6 attracted the attention of physicians to the reduced overall
7 cost of treatment of the patient using declomycin as
8 compared with another broad spectrum antibiotic with which
9 it is highly competitive, and I refer to chloramphenicol.

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MR/dpw

1 This requires an understanding of the fact
2 that Declomycin persists longer in the system after dosage
3 stops, and of the fact that a smaller milligram dose of
4 Declomycin is effective, and then having regard for the
5 cost per capsule. These three factors have to be
6 taken together in order to clarify this point, and this
7 we find the physician very much interested in.

8 I am sorry I do not have an example of this
9 sort of thing with me, but this is a straight calculation
10 in economics and a typical course of treatment and it has
11 regard for the overall cost of the treatment for one drug
12 as compared to the other. Just price competition.

13 MR. WAHN: Could this be considered direct
14 evidence of price competition in the field of antibiotics?

15 MR. THOMPSON: Oh I think so. Very much so.

16 MR. WAHN: Referring towards the end of your
17 remarks Mr. Thompson to patents and the position that the
18 company, that your company takes with regard to the neces-
19 sity of patent protection, have you any particular reason
20 to think that a position of the companies which have spent
21 extensive amounts on the development of patent invention
22 would be prejudiced to any serious extent if patent protec-
23 tion were relaxed in Canada?

24 MR. THOMPSON: Oh I certainly do. Very much
25 so. Last year our company screened between two and three
26 thousand chemical substances for possible anti-cancer
27 activity. By that I mean that these chemicals were one by
28 one studied for their possible pharmacological action on
29 malignant tumours and this will be repeated again in 1961.
30 Hopefully something of use, something of benefit for



1 management of cancer will emerge. I can't say that the
2 programme has been successful up until now.

3 I would hope that if we should succeed that
4 there would be available to us sufficient protection to
5 make it possible to recover the cost of that over the
6 world-wide business, and the company is active in 84
7 countries. I believe that this cost should be shared by
8 the people who benefit, and I don't know how this can be
9 accomplished without some sort of patent system.

10 MR. WAHN: It has been suggested on occasion
11 Mr. Thompson that even if patent protection were relaxed,
12 the companies can still derive means of keeping their
13 process that they have developed secret. Is this a prac-
14 tical alternative?

15 MR. THOMPSON: I think this would be excee-
16 dingly unfortunate. Ordinarily in a patent, in order to
17 achieve patent protection a company must disclose the
18 details of its invention. As I understand it, now I am
19 not a patent expert but my understanding is that the
20 purpose of this is to make it possible for others to bene-
21 fit from this work and to extend it into other fields and
22 be able to open it. Now if instead of publishing the
23 details of the discovery, they were simply kept secret
24 then I would suggest that the process or research would be
25 tremendously hampered and that the chance of discovering
26 additional new drugs would be reduced very greatly. I
27 think it would be a most unfortunate thing.

28 THE CHAIRMAN: Isn't it also a reason for
29 having the details of the invention disclosed so that it
30 can be seen? Would that be equally one of the reasons?



1 MR. THOMPSON: Yes, indeed.

2 THE CHAIRMAN: If you have a patent which is
3 not disclosed, pretty hard to identify it.

4 MR. THOMPSON: Yes. Well there is one
5 country of course, where patents have been abrogated
6 already. I am referring to Italy. I will give you an
7 example of how this can demoralize research incentive.

8 This is a photographic copy I have of a page
9 from a magazine, Chemical and Engineering Needs, May 30th
10 1960 and this advertisement says: "Processes wanted.
11 Foreign manufacturer seeks information or consulting
12 services for production of antibiotics, vitamins, steroids,
13 and pharmaceutical chemicals by microbiological and synthe-
14 tic organic techniques. Products will be sold only in
15 foreign countries where patents do not apply. All replies
16 will be held in strictest confidence. Unusually attractive
17 compensation. Write to representative presently in U.S.A.,
18 Dr. Angelo Mancuso, 15 Bergen Boulevard, Fairview, New
19 Jersey".

20 This address is 20 miles from Lederle
21 Research Laboratories at Pearl River, New York, and is an
22 open invitation to our employees to steal secrets and
23 peddle them for personal research to this gentleman whose
24 name sounds Italian to me, and to me this is a form of
25 piracy. The kind of competition that we have found in
26 Canada in recent years.

27 MR. WAHN: I don't think I have any further
28 questions Mr. Chairman.

29 THE CHAIRMAN: There was one topic that I
30 thought perhaps you might get a little more elaboration on



1 is this matter of companies finding it more profitable to
2 develop their own product rather than to take compulsory
3 licence. To a layman like myself who doesn't know just
4 how these things work, it would seem on some occasions
5 it might not be as profitable to have this situation: it
6 would seem that another company has developed a new drug
7 in which it has a patent. If you want to compete with it,
8 you have the expensive research project to produce the new
9 drug. If you get a licence, either voluntarily or compul-
10 sorily you save a great deal of that research expense.
11 Against that you have to pay a royalty. It would seem to
12 me that there might be in a number of cases where the
13 expenses might be pretty much the same, that you might on
14 balance be better off to take a licence and pay the royalty,
15 depending on the amount of sales you could get, and what
16 the cost of research would be and what the royalty is.

17 MR. THOMPSON: If I were the established
18 manufacturer in that situation, I would have no fear of
19 that kind of competition. Physicians once having become
20 acquainted with a drug, and we see this in our own company,
21 Achromycin, to which I have alluded, has been widely used
22 by many physicians. When Declomycin, which we think is an
23 improvement, became available we set out thinking that
24 physicians were entitled to know about this new drug, and
25 selfishly thought we would be less exposed to imitative
26 type of competition. We set out to explain this in
27 detail to physicians. We encountered the most conservative
28 form of loyalty to Achromycin that you can imagine.

29 Physicians said - many, many of them have
30 said - I am sure Dr. Warminton will bear this out - I am



1 using Achromycin. I get fine results. My patients
2 recover. Side-effects are no problem. Why should I
3 change? Why should I change to Declomycin? The best
4 efforts produce only a slow rotation.

5 Now consider the problem in that situation,
6 entering the market with not an improved preparation, such
7 as Declomycin is but an identical preparation Mr. Chairman.

8 THE CHAIRMAN: That is just what I am trying
9 to get. I thought your argument is supporting the question
10 that I am raising because if it is the identical product
11 the physician would not be making a change.

12 MR. THOMPSON: On the contrary, he forms an
13 attachment - it is difficult to remember so many new
14 products. When he finds one that he understands and likes,
15 he gets familiar with the packaging and he writes the
16 prescription from memory. He becomes loyal, I suppose is
17 the best word, to that preparation.

18 THE CHAIRMAN: To the name apparently?

19 MR. THOMPSON: Perhaps so, to the name or to
20 the company.

21 THE CHAIRMAN: Or to the company.

22 MR. THOMPSON: To me this is the same thing.
23 If you prefer to prescribe tetracycline Lederle rather
24 than Achromycin, it seems to me that this is just the same
25 thing.

26 THE CHAIRMAN: If the product is identical,
27 you do not have to sell him something that is better or
28 different, but it is identical, why should it be so diffi-
29 cult to get him to prescribe this one or this one or this
30 one, all being identical?



2 1 MR. THOMPSON: They are not very often

2 identical Mr. Chairman.

3 THE CHAIRMAN: I was thinking of where you
4 are producing it under licence.

5 MR. THOMPSON: Each manufacturer seeks to
6 improve by the method of formulation on his competitor.
7 If the basic drug entering the formulation is identical,
8 he seeks to improve the presentation of it.

9 THE CHAIRMAN: Does he not do that by getting
10 another patent?

11 MR. THOMPSON: No. Normally one cannot do
12 this. Ointment bases, there are many of them available,
13 you can put your drug in petrolatum which does not readily
14 mix with water. Another manufacturer, and this has
15 happened, has put his antibiotic in a base which mixes
16 readily with water and he can show how successful this was
17 with the antibiotic. Same kind of antibiotic; produces the
18 same treatment for the patient. Simply a case the vehicle
19 is different.

20 The antibiotics are the same, the same pro-
21 cess, comes from the same source but the finished drug
22 differs, and he trades on that difference with the physi-
23 cian, and the physician is reluctant to certainly switch
24 from day to day. He finds one and sticks to it.

25 The same is true of antibiotic capsules
26 where, for example, the Achromycin capsule is a dry filled
27 capsule in a soft, elastic capsule whereas some of the
28 competitive preparations are in a hard shell capsule.
29 These are differences which may affect the action of the
30 drug on the patient. The physician generally does not



1 take those risks. He forms an attachment to the one that
2 is originally drawn to his attention. He is a little
3 reluctant, a little resentful when someone comes and
4 claims his interest for what appears to be an imitation.

5 THE CHAIRMAN: Even if it is an improvement?

6 MR. THOMPSON: If it is an improvement, you
7 had better express yourself pretty clearly so he will
8 understand it.

9 THE CHAIRMAN: I thought detail men always
10 expressed themselves clearly to that effect.

11 MR. THOMPSON: We try to bring that about.

12 THE CHAIRMAN: You have been on your feet
13 for quite a while. Perhaps we had better have a short
14 break.

15

16 --- Short Recess

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1 THE CHAIRMAN: We will resume the hear-
2 ings, ladies and gentlemen. Have you completed your
3 questions?

4 MR. WARMINTON: Yes, I have no further
5 questions.

6 THE CHAIRMAN: Mr. Whiteley?

7 MR. WHITELEY: In regard to your
8 suggestion as to the conclusion as to having publications
9 which give the information which would be available to
10 the medical profession, the implication is this would
11 reduce, in some way, the promotional costs now incurred
12 by members of the industry. Does your thinking go in
13 the direction there would be any restriction placed upon
14 the promotional activities of the individual companies?

15 MR. THOMPSON: I don't think it would
16 be necessary. What I would like to do, as I tried to
17 say, is that I would like to see the efficiency sharply
18 increased of the money which is spent on promotion, so
19 that the communication with a physician which might now
20 cost a dollar might cost somewhat less with the
21 assistance of this publication. Am I answering your
22 question?

23 MR. WHITELEY: Do you see it taking
24 place as a natural consequence rather than any directed
25 reduction in individual promotion?

26 MR. THOMPSON: Oh, yes, I think it is
27 very difficult -- it is a very difficult decision for a
28 manufacturer to say. He is confronted by a dilemma,
29 shall I increase my price and promote more substantially
30 or reduce my price and promote less, but talk about price



1 more. This is a rather difficult and delicately balanced
2 decision. You can be very wrong either way. Therefore,
3 when a better method of reaching the physicians is
4 found I would expect an immediate downward pressure of
5 promotional activity.

6 MR. CARIGNAN: Mr. Thompson, on page
7 43 and page 44 you state the reasons why a compulsory
8 licence in the Canadian Patent Act is not being utilized
9 -- for instance, on page 43 that you say a small
10 manufacturer would, first of all, have to have facilities
11 that would cost him \$1,000,000.00. On the next page,
12 you state, for instance, that for the big manufacturer
13 it is simply not profitable to market a product developed
14 by a competitor who is fully established himself in that
15 market. If all this is true, if these things are the
16 real reason which prevent new entrants you don't need
17 any patent protection at all, the same result would
18 exist.

19 MR. THOMPSON: That is true provided
20 the cost of getting started is a million dollars. It
21 is not, always, of course. I think I was talking in one
22 case in terms of specific examples of tetrocycline
23 antibiotics where I mentioned the one million dollars.

24 MR. CARIGNAN: So, you mean, that in
25 many other cases the royalties would be a serious
26 detriment?

27 MR. THOMPSON: Yes, you see if the
28 imitator comes into the market without paying the royalty,
29 in other words, if he comes in in violation of the
30 Patent, he bears no research costs. He has not any



1 investment in the product and has the additional
2 economical latitude if you like, to spend money on
3 promotion. He has got nothing to lose. As long as he
4 promotes, he has no investment to recover. He can just
5 come in and attempt to take away the business of an
6 established company with no penalty, whereas the origin-
7 ator has suffered the penalty through his research. He
8 made an investment in research.

9 THE CHAIRMAN: Can he adopt the process
10 without going to any expense to produce that product?

11 MR. THOMPSON: No, there is always some
12 cost to get started with a process, but an knowlegable
13 person can get a copy of a patent for 25 cents, American
14 patents for example, and a similar charge in Canada.
15 I am not sure I am answering your question or understand
16 it.

17 THE CHAIRMAN: If he goes in to make
18 an infringement of the patent, a patent on the process of
19 a drug that has taken the patantee a good deal of research
20 and expense to put himself in the position to make the
21 product, develop the product, I was wondering how any-
22 body could just very easily reproduce that process and
23 turn out the product. He has not been given a licence. He
24 has not been told by the patentee. He has to find his
25 way. How can he do it without incurring expense?

26 MR. THOMPSON: He simply gets a copy
27 of the patent from Ottawa. My understanding is that the
28 patents are public property.

29 THE CHAIRMAN: He would simply make a
30 search of the Patent Office?



1 MR. THOMPSON: Yes, and in a case I have
2 checked on this particular situation, in the case of
3 Declomycin, which I mentioned, the drug is made possible
4 by a special culture amulant in the organism which
5 happens to produce a high wealth of declomycin. There is
6 on file in Washington, there are on file samples of the
7 culture. It is freely available so that a would-be
8 violator not only can get a copy of the patent, but also
9 a sample of the culture which to follow.

10 THE CHAIRMAN: He would still have to
11 do a lot of work to produce the culture?

12 MR. THOMPSON: A culture can be grown
13 just as you breed rabbits, once you get started.

14 THE CHAIRMAN: Once you get started.
15 It might have

16 MR. THOMPSON: \$1.00 and he can write
17 to Washington and get a sample of the culture which is
18 what he needs to start.

19 THE CHAIRMAN: Get it going from that?

20 MR. THOMPSON: Yes.

21 THE CHAIRMAN: I don't think we have on
22 record, I don't know whether you are able to tell us this,
23 but I was wondering if you could tell us whether there
24 is a pretty thick scale of royalties on the drugs?

25 MR. THOMPSON: I don't know. I haven't
26 made a study of royalties, but I do suggest that the
27 royalty must have to vary very widely. I will go back
28 to this example for the raw material -- I don't know, I
29 am not sure of the cost per ton of the raw material of
30 this substance. Mr. Bowman, do you happen to know?



1 Is is very low. It is crude material. The method of
2 producing it has been known since 1907 when it started,
3 nothing new about the process. The thing new about this
4 substance is the fact it can be used as a drug.

5 THE CHAIRMAN: You had better indicate
6 what it is.

7 MR. THOMPSON: I beg your pardon. It
8 is calcium cartimide which I mentioned earlier. This is,
9 incidentally, an opportunity for me to point up an error
10 in the Director's statement that I haven't mentioned.
11 First, let me say our company spent \$182,000.00 in the
12 United States on the research which led to the develop-
13 ment of this substance as a drug. Now, the cost of the
14 raw material is very small and the royalty, if applied
15 to the cost of the material would have to be a high
16 percentage because, as I understand our Patent Act, the
17 originator, the patent holder -- we don't have a patent
18 on this substance, but if we did we would be entitled
19 to a royalty commensurate with the effort of producing
20 the invention. Here is the situation where a company
21 has discovered the use of this substance as a drug, has
22 a considerable investment to recover, and therefore, if
23 we were to licence this on a royalty basis, we would
24 have to find some way of recovery \$182,000.00 as a
25 factor in the cost of the material. I suspect the cost
26 of the material would be quite a lot more than the cost
27 of the substance.

28 THE CHAIRMAN: You wouldn't expect the
29 royalty to return the whole \$182,000.00 from one licensee?

30 MR. THOMPSON: No, of course not.



1 THE CHAIRMAN: Your royalty would be
2 on the profits, that is what you patent, the process
3 rather than the raw material itself.

4 MR. THOMPSON: Well, yes.

5 THE CHAIRMAN: The royalty would have
6 some relation

7 MR. THOMPSON: We would have to measure
8 at some stage of the process, we would have to apply the
9 royalty, it could be on either raw material or on the
10 sale of the finished product.

11 THE CHAIRMAN: For a compulsory licence
12 it would be fixed?

13 MR. THOMPSON: It would be fixed.

14 THE CHAIRMAN: If you couldn't agree on
15 what the royalty would be it would be fixed by the
16 government authorities?

17 MR. THOMPSON: Indeed it would, and if
18 the Commissioner did not have regard for the cost of
19 the developing of the product, I suggest that the royalty
20 could be quite unfair.

21 THE CHAIRMAN: Have you had an experience
22 as to where the royalties set on a compulsory licence
23 have been unreasonably low?

24 MR. THOMPSON: No, I haven't. In my
25 experience, Mr. Chairman, there have been very few
26 compulsory licences.

27 THE CHAIRMAN: There have been some
28 comments in the material we have covered about royalties
29 giving very little return to the patentee who has to
30 give the licence. I wondered if we could get any data



1 on that?

2 MR. THOMPSON: I am sorry, from my
3 experience I can't be very helpful.

4 I would like to say, I mentioned
5 \$182,000.00 as having been spent on research. The
6 Director in his statement secured the figure from our
7 company as to the amount of research that we had spent
8 on research in one particular year. I think it was 1959.
9 The figure was \$1200.00. He prepared that as \$1200.00
10 spent in Canada with \$12,000,000.00 which our company
11 spent in the United States. The Director did not answer
12 how much was spent in Canada on our behalf by our parent
13 company. We were only asked how much we, Cyanamid of
14 Canada spent. We answered the question in that way.
15 The fact is that that \$1200.00 was on Tempcsil. That is
16 by no means the whole story. During the two years,
17 1959 and 1960 our American Company spent \$72,800.00 on,
18 just on research and education grants in Canada, and
19 that would have to be added to \$1200.00 in order to
20 form an accurate picture.

21 THE CHAIRMAN: Of your total research
22 expenditures?

23 MR. THOMPSON: Of our total research
24 expenditures in Canada.

25 MR. WAHN: One question was asked I
26 would like to refer to, why was any patent protection
27 needed at all. I believe it was by Mr. Carignan, in
28 view of the fact that large expenditures in plants would
29 be required so a small manufacturer couldn't get into
30 business. In any event, in your experience, Mr. Thompson,



1 would you say that protection is necessary not only to
2 protect someone who has developed at great expense a
3 new drug against other manufacturers in Canada, but also
4 equally, and perhaps more so, against those who propose
5 to import a product from other countries where patent
6 protection does not exist? Would you also comment, if
7 you would, on the effect of lack of patent protection
8 upon the development of research within a country?

9 MR. THOMPSON: First of all, it is a
10 very simple thing for a manufacturer in Italy who operates
11 immune from patent law to manufacture a product in
12 which a company like my own has made a substantial
13 investment in research and to do so without paying any
14 tithe for that privilege and then to export that drug
15 to Canada where it is admitted freely and sell it here
16 in competition with me. That is a very simple mechanism
17 for averting the cost of research and we, I find my
18 company in the position of having to compete with an
19 imitator who bears no burden of research. To my way of
20 thinking patents are absolutely essential. You had an-
21 other question?

22 MR. WAHN: The second question, whether
23 in your view if the patent, present patent protection in
24 Canada was seriously diminished, would that prejudice
25 the development of the future of Canadian research?

26 MR. THOMPSON: Oh, yes, indeed. Mr.
27 Bowman and I have strong ambitions for creating a research
28 organization within our company in Canada along the
29 lines of the Institute at Geneva. We would like to start
30 by applying research, practical research leading to



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1 products at our various plants. I wouldn't want the
2 duty of asking the stockholders of our company for the
3 money to set up research facilities in a climate where
4 there was no hope of reward by research.

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1 I am sure that it would not be approved. I am a
2 Canadian and I don't like to see Canadians leaving the
3 country simply because they cannot find employment in
4 research activities in Canada. So that I think it
5 would be a most unfortunate thing if the only encourage-
6 ment that we have to research in Canada were weakened
7 or limited.

8 MR. WAHN: In your evidence you have
9 said that up to the present time there has been -- that
10 research in Canada in this particular field has been
11 somewhat limited. Is there any reason to think that
12 must necessarily continue in the future, or is there
13 any chance of increased research in Canada in this
14 field?

15 MR. THOMPSON: No, I think there is
16 every hope that research activities will develop in
17 Canada. We have excellent people here. We have excellent
18 academic centres where we do have some research. The
19 Ayerst Company has an excellent pharmaceutical research
20 set-up in Canada. So has the Charles Frosst Company,
21 and to some extent so also has the Frank Horner Company.

22 I believe this is just the beginning.
23 These are merely beginnings, but they reflect the confi-
24 dence that these companies have in the talent that is
25 available, and, as I think I said in my comments, it is
26 becoming increasingly necessary for the mountain to
27 come to Mohammed, Mohammed being the technically trained
28 people.

29 I think if research is a world wide
30 effort, in our company it is not all done in the United



1 States, and I believe it will become increasingly de-
2 centralized so as to take the best advantage of all the
3 skills and talents available all over the world, and I
4 think Canada is one of the best candidates for that.

5 THE CHAIRMAN: Do you think that there
6 are no over-balancing advantages in concentration of
7 research?

8 MR. THOMPSON: Well, research occurs
9 at several levels, Mr. Chairman. You have the pure
10 research, for example, the technique of tissue culture
11 which made possible the Salk vaccine and development.

12 The technique of tissue culture is a
13 science which had to be understood and developed before
14 it could be used for the production of any vaccine.
15 This, if you like, is fundamental research, not done for
16 the specific purpose of making Salk vaccine, but in the
17 hope that it would have some application as a fundamental
18 form of research. Much work was done in this very field
19 right in Canada by the Connaught Laboratory. So that
20 there are elements of research that I believe can very
21 well be decentralized into a country like Canada.

22 I think there are others where the
23 centralization of facilities is a big advantage. Pilot
24 plant operations where you make your first small amount
25 of a new drug, can perhaps best be associated with a
26 large production unit where the know-how can be traded
27 back and forth.

28 The research in the pharmaceutical industry
29 is becoming increasingly basic. It is increasingly a
30 thing which can be done in university teaching centres,



1 under grants, and where decentralization I think is not
2 only practical but necessary. There are just not enough
3 trained people.

4 THE CHAIRMAN: Your view, then, is that
5 the domination of American company research in the
6 Canadian industry, which is associated with the fact
7 that most of our drug companies are subsidiaries of
8 American companies, that would tend to become less as
9 time goes on, and more research would be done in Canada.

10 MR. THOMPSON: I think there is a strong
11 trend for the American companies operating in Canada to
12 make their Canadian subsidiaries increasingly independent.
13 Rather than being branches tied to the apron-strings,
14 like a branch usually is, they are becoming separate
15 corporations. They are begining to have their own
16 presidents, to have their own Board of Directors. They
17 make decisions which are oriented strictly to Canada,
18 rather than being part of a larger decision made in the
19 United States.

20 This trend I think is a very healthy one
21 because it encourages creativity and originality within
22 the Canadian company, and when one finds facilities like
23 the Montreal Neurological Institute and the Banting
24 Institute, the first thing which you hope is that you
25 can find how to work with these people and take advantage
26 of them and take advantage of their skills, and marry
27 them up with the commercial facilities of the company,
28 and Canada has some excellent facilities.

29 THE CHAIRMAN: There are one or two
30 questions that occurred to me with reference to Italy.



1 We have not this on the record, I think. Perhaps you
2 can answer it. Do you happen to know to what extent
3 research in drugs is carried on in Italy, where they
4 have no patents?

5 MR. THOMPSON: A few days ago, Mr.
6 Chairman, I was talking to the research director of our
7 American company who has been very interested in this
8 situation, and I can only quote what he told me, and that
9 was, that not one new drug of any consequence has been
10 developed in Italy since the patent law was abrogated.

11 THE CHAIRMAN: Another question would
12 be this: This may be something you cannot answer, but
13 you may have seen the information: To what extent do
14 the Italian drug manufacturers depend upon exports?

15 MR. THOMPSON: I am sorry.

16 THE CHAIRMAN: I thought that might be
17 one you could not answer.

18 MR. THOMPSON: I might be able to find
19 out, but I don't know.

20 THE CHAIRMAN: Perhaps we can find it
21 out, I don't know. We have not the same facilities for
22 getting information in other countries as in Canada.

23 MR. THOMPSON: We do have an organization
24 in Italy. In fact, we have an antibiotic plant there,
25 and it might be possible to get some indication of that
26 for you.

27 THE CHAIRMAN: We might be interested
28 in that, because it bears on the whole question of the
29 extent to which the Italian companies are simply imitators
30 making a profit by selling in other countries where



1 patent laws don't stop them coming in, rather than
2 producing, carrying on research and also producing and
3 selling in their own country.

4 MR. THOMPSON: I do know, Mr. Chairman,
5 that our company has in encountered this type of --- and
6 I am going to call it "piracy" in many countries, not
7 just in Canada. It is very extensive, I know that.

8 THE CHAIRMAN: Are there any other
9 questions that representatives of other organizations
10 would like to ask?

11 MR. HUME: I have a couple of questions.
12 Mr. Thompson, that sample you have of calcium carbamide,
13 some of my learned friends on my left want me to ascertain
14 that it is well corked and well secured. Your evidence
15 was that exposure to it could produce some serious side
16 effects, and we hope it is well corked.

17 MR. THOMPSON: This has been called,
18 the pill that makes you pink when you take a drink.

19 MR. HUME: I just want to make sure the
20 bottle is securely fastened.

21 MR. COOK: My friend is talking about
22 his friends on his left. What I said was, "I don't
23 think this should be disposed of without notice to Mr.
24 Warminton.

25 MR. HUME: I have three very brief
26 questions. On the discussions ~~that~~ you have had with the
27 members of the Commission and my learned friend Mr.
28 Wahn, on the question of compulsory licencing of patents,
29 I don't know whether it has come out or if it has, I
30 have missed it, the compulsory licencing of the process



1 does not I suppose carry with it the right to use the
2 name that your promotion has developed with respect to
3 that particular product?

4 MR. THOMPSON: No, my understanding is
5 that the registered trade mark, brand name, whatever you
6 call it -- I am not sure which is the correct expression,
7 -- but this word "Temposil" is registered as a trade
8 mark. Is that the correct terminology, that is the
9 trade mark?

10 MR. HUME: That is the trade name.

11 MR. THOMPSON: The trade name. This
12 assuredly does not go with the compulsory licence.

13 MR. HUME: So that one of the factors
14 that a rival of yours who decided that he might like to
15 apply for a compulsory licence for your process -- one
16 of the factors he has to take into consideration is that
17 he has to generate a demand for the same product under
18 his name ? Is this not the situation?

19 MR. THOMPSON: Yes, either that or he
20 has to persuade people to give him part of our business
21 through the use of generic names.

22 MR. HUME: And in some cases the generic
23 name is a long name and hard to remember and hard to
24 spell?

25 MR. THOMPSON: Yes, the generic name for
26 this substance is calcium carbimide citrated, and the
27 trade name is Temposil.

28 THE CHAIRMAN: The chemical name is even
29 longer.

30 MR. HUME: So that the applicant for the



1 compulsory licence, in addition to whatever problems he
2 may have about plant and machinery and so on, has got
3 to start with a long unpronounceable name and generate a
4 demand for it in the minds of the prescribing physician
5 which, would you agree with me, would be a further
6 deterrent as to why he would not be too enthusiastic
7 about applying for a compulsory licence.

8 MR. THOMPSON: That fact, plus the
9 royalties he would have to pay, would be the principal
10 deterrents and powerful deterrents they are. A physician
11 does not like being approached and told "This is the
12 same thing made by my company, so please buy it from me".
13 He already has the source available and has developed
14 confidence in that drug, and nothing new is offered
15 except that the second company is also in the business
16 and the physician finds it confusing and difficult ,
17 and he does not like that.

18 MR. HUME: It seems to me, Mr. Thompson,
19 listening to your evidence, a further factor might be
20 that if he applied for a compulsory licence on the process
21 if that product is merely a refinement of something you
22 produce by the hundreds of thousands of tons in bulk,
23 that he could now manufacture that product provided he
24 didn't use your process, provided he developed his own
25 process for refinement?

26 MR. THOMPSON: Yes.

27 MR. HUME: So that he would not need
28 a compulsory licence except where he needs your process?

29 MR. THOMPSON: No doubt that is true.

30 MR. HUME: That may have been clear to



1 you, but it was not completely clear to me.

2 Then, on the question of research, I take
3 it from your evidence, Mr. Thompson, that while there is
4 as you point out a relatively small amount of research
5 being actually done in Canada, would it be your opinion
6 that Canadians are paying their own way in research?

7 MR. THOMPSON: Yes.

8 MR. HUME: That is to say, we are
9 benefitting by research done in other countries, in other
10 parts of the world, but we are paying for that in the
11 cost of the products that we either import or obtain by
12 some arrangement that the companies have, is that right?

13 MR. THOMPSON: Very, very definitely.

14 MR. HUME: So that when a Canadian
15 produced product is sold where research is done in the
16 United States, part of the cost of the product in the
17 Canadian company is an element of research in the other
18 parts of the world?

19 MR. THOMPSON: Yes, and that amounts to
20 9.6 per cent of sales.

21 MR. HUME: Thank you. My last question
22 has to do with your section on promotional literature.
23 The Commission has indicated interest in this in other
24 places, and you covered it in your brief starting at
25 page 20. I want you to direct your attention to a
26 submission in the Green Book on page 118. I would like
27 to read you paragraph 194 and ask you to comment on it.
28 The Director in referring to this matter of promotion
29 is quoting from Newsweek, and I will read the quotation.

30 "194. There is evidence that some of



1 the drug manufacturers themselves feel
2 that promotional methods have gotten out
3 of hand and that the present large expen-
4 ditures are not justified. The following
5 item appeared in Newsweek on May 16,
6 1960: 'While the drug manufacturers
7 are naturally reluctant to discuss
8 strategy, they have already indicated
9 clearly exactly where some of these steps
10 will lead. The targets:
11 Promotion: Connor (John T. Connor,
12 President of Merck and Company) has
13 admitted, and most other drug manufacturers
14 agree privately, that promotion expenses
15 -- the huge volume of direct mail adver-
16 tising to doctors, visits by detail (pro-
17 motion) men, and extensive advertising in
18 medical journals -- have gotten out of
19 hand and must be checked.'

20 That is a quotation from Newsweek,
21 Mr. Thompson. Will you comment on that with relation
22 to your own company?

23 MR. THOMPSON: If Mr. Connor meant by
24 that, that he would like to see the cost of marketing
25 reduced or a greater efficiency introduced, then I
26 would agree with him. I would like to see that happen,
27 too. But I don't for one minute think that the cost
28 of marketing has gotten out of hand, and certainly I
29 don't think it is true in my own company.
30



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1 MR. THOMPSON: If I could find a way to get
2 an extra 10% of efficiency out of the promotional dollars
3 my company spends I would be delighted, and I would go to
4 great pains to do so if I thought I knew how to do it.

5 Now, the suggestion we made in our conclu-
6 sions here was one we believe is practical and may be a
7 step in that direction, but the cost of reaching this
8 market is very high.

9 If you could imagine, Mr. Hume, taking a
10 population of a town the size of Orillia, with fifteen or
11 eighteen thousand people, this is the size of the medical
12 population of Canada. If all the doctors in Canada were
13 in that one town, there would be a totally different
14 problem in promoting pharmaceuticals. We would use tele-
15 vision, radio, and other mass media, and reach these physi-
16 cians much less expensively, but that is not the way it is.
17 These people are spread out from coast to coast along a
18 line which is more than 4,000 miles long, and each physician
19 is at the centre of a group of citizens, 1,000 citizens,
20 who don't understand these products and don't want to know
21 anything about them. Our assignment is to avoid, according
22 to law we must avoid promoting to the 1,000 people, but we
23 must penetrate that group and reach the physicians, and
24 reach his intellect and appeal to him on the basis of cold
25 logic, and win his confidence, and this is undeniably
26 expensive.

27 I don't know other than the suggestion we
28 have made how anything can be done to reduce that burden.
29 Somebody has to do this work on new drugs.

30 MR. HUME: You don't agree with the



1 statement in the Green Book that the present large expendi-
2 tures are not justified? You consider they are justified?

3 MR. THOMPSON: I don't know of any way to
4 reduce them, Mr. Hume. I just wish I did. I don't think
5 it is out of hand. I think that the levels of promotional
6 expense are the result of many years, 80 years of experi-
7 ments. During that period almost every conceivable combi-
8 nation of promotional methods has been used in an effort
9 to seek a more effective way. I think that the methods
10 that are being used now are the best that have ever been
11 devised, and most efficient, and I don't think we are out
12 of hand.

13 MR. HUME: Thank you very much.

14 THE CHAIRMAN: Just on that point, I am not
15 quite sure that I understand exactly what Mr. Connor
16 meant by "being out of hand". Is it your experience or
17 is it not over the years that your company has had to step
18 up its expenditures on literature, on intensity of
19 detail interviewing or other matters of promotion because
20 other companies have been doing that to a greater and
21 greater extent?

22 MR. THOMPSON: Well, I have never believed
23 that intensification by my competitor creates the need for
24 me to increase the intensity.

25 THE CHAIRMAN: Unless he is taking your
26 business away?

27 MR. THOMPSON: Yes, but this is not an easy
28 thing to do if I am there first. I do think that certainly
29 it is true these expenditures have risen, but I think the
30 reason is rather that the new drugs that are now available



1 are more potent, more complex, and the conservative
2 physician - and he is rightly so - wants to have an
3 increasingly complete story, increasing reassurance, as a
4 drug becomes more potent before he will use it.

5 I would attribute any increase to the nature
6 of the new drug rather than to the intensity of competitive
7 activity.

8 THE CHAIRMAN: You don't think intensity of
9 competitive activity has been a contributing cause?

10 MR. THOMPSON: No, I don't think so, no.

11 THE CHAIRMAN: We often think it is in some
12 other industry, but we may be wrong in that.

13 MR. THOMPSON: It reaches a balance, Mr.
14 Chairman, because if my competitor increases his effort
15 and I increase mine to match it, it is necessary for us to
16 raise our prices to finance it, and pretty soon somebody
17 comes along with a price-cut, and it is terminated automa-
18 tically.

19 THE CHAIRMAN: They can't cut either?

20 MR. THOMPSON: That is true, but maybe I
21 will cut first like we did last year with the antibiotics.

22 THE CHAIRMAN: Any others here representing
23 groups or individuals?

24 MR. FRAWLEY: On page 22 of your brief you
25 say that advertising to the public is forbidden by law,
26 and you associate that with the necessity for these promo-
27 tional programmes. I wonder what you mean by saying it is
28 forbidden by law because I have here the Montreal Gazette
29 of the 22nd of June last, in which the Sandoz Company
30 advertised in particularity and mentioned particularly a



1 development called Delysid or LSD-25, a drug which has
2 proved helpful in speeding up treatment of the mentally
3 ill and alcoholics. I am sorry we have to keep on that
4 this afternoon.

5 THE CHAIRMAN: A great fascination.

6 MR. FRAWLEY: Why do you say, because you
7 know a lot more about this than I do, why do you say they
8 are prohibited by law?

9 MR. THOMPSON: I am referring to prescription
10 drugs, Mr. Frawley, and I don't know that product so I
11 can't comment on it. It is specifically prohibited by the
12 Food and Drug Act, for example, to promote any drug for
13 heart disease. There is a list of specific diseases in
14 the Food and Drug Act, for which any promotion is forbidden
15 specifically.

16 It is also - I think I am correct when I say
17 this - it is not permitted to promote any drug bearing a
18 PR legend on the label. Dr. Warminton, do you know is
19 that true?

20 DR. WARMINTON: I believe that is true.

21 MR. THOMPSON: I cannot quote it because I
22 don't have a copy, but I am quite sure that is true. In
23 any event, it would avail the manufacturer nothing to
24 promote to the public prescription drugs because the
25 consumer can't go in and buy it anyway without a prescrip-
26 tion.

27 MR. FRAWLEY: Well, I can understand that,
28 and I was going to say I wondered why you didn't say that.
29 There wouldn't be any point in taking half a page in the
30 Ottawa Citizen and describe your Achromycin in great



1 detail, so you say it is because of that that you have to
2 spend so much money on sampling the doctors and the drug-
3 stores and the hospitals and the out-patient departments -
4 so many people?

5 MR. THOMPSON: We have to reach people who
6 cannot be reached by the normal mass media. We have to
7 have recourse to the most efficient methods in the circum-
8 stances. That is what I am trying to say.

9 MR. FRAWLEY: Now, Dr. Thompson, you make
10 Aureomycin and Achromycin?

11 MR. THOMPSON: Yes.

12 MR. FRAWLEY: And you list them at the same
13 price to the druggist. Now, you have been making Aureomycin
2 14 since 1949, and Achromycin only within the last few years?

15 MR. THOMPSON: 1953.

16 MR. FRAWLEY: Why do you keep Aureomycin at
17 the same price as Achromycin? Your brief says Achromycin
18 is much more expensive to make. Why do you not let the
19 list price reflect the lower cost of the Aureomycin?

20 MR. THOMPSON: Well, Mr. Frawley, Aureomycin
21 - my comments referred to the cost of manufacturing the
22 bulk chemical. This is not the whole story, and it is
23 more expensive to make Achromycin in bulk than it is to
24 make Aureomycin in bulk. Once having produced the bulk
25 material, process of manufacture is not complete and one
26 must then take the bulk in each case and prepare it into
27 injectible dosage forms, capsules and ointments. As Achro-
28 mycin has prevailed in the market place, so Aureomycin has
29 decreased in volume, and the preparation in all dosage
30 forms of Aureomycin is becoming increasingly expensive



1 because we now buy fewer tubes and fewer labels. We have
2 shorter packaging runs.

3 We have the same number of items to maintain
4 in inventory, but with decreasing sales volume, and there
5 is a very definite decrease in sales volume on Aureomycin
6 so you have two factors at work; not just one.

7 MR. FRAWLEY: Well, Mr. Thompson, if you let
8 the cost factor get into your pricing to a larger extent,
9 wouldn't the doctor who was anxious, as some of them I am
10 sure are, to put his patient to the least possible drug
11 expense, would he not be able to prescribe Aureomycin
12 rather than Achromycin? He might think in his own mind
13 that the Aureomycin would give his patient the same benefit
14 as the more expensive to make drug.

15 MR. THOMPSON: If he feels that way, Mr.
16 Frawley, I would like to have an opportunity to talk to
17 him about the differences between Achromycin and Aureomycin
18 which he presumably does not understand.

19 MR. FRAWLEY: Then my question was a very
20 ill-advised one. There is no such thing as a doctor pres-
21 cribing Aureomycin for the same condition or approximately
22 the same condition rather than Achromycin?

23 MR. THOMPSON: In all fairness there is an
24 occasional case where that is true. If you remember
25 reading in the papers about the unfortunate Dale family
26 in Ottawa last summer; several members of the family
27 afflicted with a very serious disease, a disease which
28 makes the children subject to infection very readily, the
29 family physician in that case chose to use Aureomycin,
30 fully aware of the fact that there was a better and more



1 potent antibiotic available, but he chose to hold them in
2 reserve because of the progressive nature of this disease.

3 In these rare cases Aureomycin might well
4 be the drug of choice, and in this case we have supplied
5 substantial quantities to treat that family, but that is
6 very unusual.

7 MR. FRAWLEY: You see, Mr. Thompson, what
8 makes me ask you these questions is that it is true, is
9 it not, that there is almost an identical list price with
10 respect to many of these broad spectrum antibiotics?
11 That is so, isn't it?

12 MR. THOMPSON: Yes, I think so.

13 MR. FRAWLEY: For instance, looking at this
14 August 1960 issue of Kitlinger Magazine, which is an
15 American publication of course, they list tetracycline,
16 and Achromycin is a tetracycline?

17 MR. THOMPSON: Yes.

18 MR. FRAWLEY: In this statement, this
19 schedule of list prices, Achromycin, Lederle, to the
20 wholesaler, \$25.24; Bristol's Polycycline, to the whole-
21 saler, \$25.24; Pfizer's Tetracyn, to the wholesaler, \$25.24;
22 Squibb's Steclin, to the wholesaler, \$25.24; Upjohn's
23 Panmycin, \$29.45, and out of the five of those tetracyclines,
24 you only have one that varies by so much as one cent in
25 the list price.

26 Now, is that just inevitable, Mr. Thompson?
27 Is there no hope for the public that there will ever be
28 anything but that same rigidity in prices?

29 MR. THOMPSON: Mr. Frawley, you used the
30 word "rigidity". I thought I had related a story of very



1 delicate footwork in this industry when I told what
2 happened when our company sought to gain a price advantage
3 by lowering prices by 15%.

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Thompson

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1 When a competitor mails out a notice a few
2 hours later meeting our price, that must be an indication
3 to you, it certainly was to me of the difficulty of attempt-
4 ing to maintain a price differential in this field. This
5 is a very price sensitive market, in my opinion, and when
6 one sets up a differential the competitor immediately
7 eliminates it.

8 MR. FRAWLEY: I suppose, Mr. Thompson, this
9 is true taking the list here, I suppose if Lederle brought
10 down that Achromycin price to the wholesaler at \$25.24,
11 if they brought it even down to \$25.00 that Bristol,
12 Pfizer, Squibb would all follow him immediately?

13 MR. THOMPSON: That has been my experience.

14 MR. FRAWLEY : Well is there anything
15 intrinsically wrong about that Mr. Thompson?

16 MR. THOMPSON: No, I don't think so.

17 MR. FRAWLEY: The public benefitted a little
18 bit?

19 MR. THOMPSON: Yes, indeed. I am happy to
20 say that my company started such an action last year.

21 MR. FRAWLEY: And you gave the Commission
22 that instance this morning because you were quite satisfied.
23 You were proud of your marketing leadership there I take it?

24 MR. THOMPSON: Yes.

25 MR. FRAWLEY: And the public benefitted?

26 MR. THOMPSON: I think so.

27 MR. FRAWLEY: How many instances like that
28 have you had in the last twenty-four months?

29 MR. THOMPSON: Twenty-four months? Two.

30 THE CHAIRMAN: Just to be clear was the



1 question how many instances in which Cyanamid had been
2 the first to cut or instances in which somebody had cut
3 prices?

4 MR. FRAWLEY: We take it both ways sir. How
5 many instances in which Cyanamid -- would you say that
6 Cyanamid is the market leader in Tetracycline?

7 MR. THOMPSON: It depends on what you mean
8 by leadership Mr. Frawley.

9 MR. FRAWLEY: Imperial Oil is the market
10 leader in the oil industry in Canada. Now, using that as
11 an example, there are other large producers and marketers
12 but Imperial is recognized as the market leader.

13 MR. WAHN: Mr. Chairman, I would like,
14 before my client answers this question, I would like him to be
15 sure he understands what the implications are. Perhaps
16 we should not associate our products with those sold on
17 gasoline.

18 MR. FRAWLEY: Very good citizens of Canada,
19 the oil company. In my province, anyway.

20 THE CHAIRMAN: I think the witness should
21 know just what ---

22 MR. FRAWLEY: We will get that. When you
23 say market leader, that is the man, in other words, that
24 sets the price. Doesn't follow anyone. He sets the
25 prices and the others will follow.

26 MR. THOMPSON: Mr. Frawley there is no
27 market leader in the antibiotic business, that I am aware
28 of. I may be the leader in October 1960 and a different
29 antibiotic may become the leader in 1961.

30 MR. FRAWLEY: I don't want to pursue this



1 business of market leader any further than it should be
2 pursued but ---

3 MR. THOMPSON: I don't think there is any
4 such thing.

5 MR. FRAWLEY: ---are you the market leader
6 as far as volume is concerned?

7 MR. THOMPSON: As far as I know, yes. If
8 you mean have we been successful, yes. I am proud of that
9 fact.

10 MR. FRAWLEY: As far as I am concerned, I
11 would regard you then as the market leader. You lead in
12 volume?

13 MR. THOMPSON: In that respect, yes, but
14 let us not say that that implies leadership in price. It
15 may or may not.

16 MR. FRAWLEY: In any event, you ---

17 MR. THOMPSON: I think that I have the
18 largest volume. That doesn't give me the right to set
19 our competitors' prices. Never has.

20 MR. FRAWLEY: Not your competitors' prices,
21 but your prices.

22 MR. THOMPSON: Well certainly. I always
23 hope that will be true.

24 MR. FRAWLEY: You have a price now -- let
25 me get my question answered first: Have there been any
26 instances, the two instances that you mentioned as having
27 transpired in the last twenty-four months, are they
28 instances where Lederle reduced a list price on an anti-
29 biotic?

30 MR. THOMPSON: Yes.



1 MR. FRAWLEY: Both instances are yours?

2 MR. THOMPSON: Our antibiotics, yes.

3 MR. FRAWLEY: In antibiotics. Can you tell
4 me -- the public benefitted in each case?

5 MR. THOMPSON: I think so.

6 MR. FRAWLEY: They benefitted as far as the
7 price was concerned?

8 MR. THOMPSON: I think this is an example
9 of competition at work that I hope will be preserved.

10 THE CHAIRMAN: Just to complete that: In
11 both cases other companies followed suit did they?

12 MR. THOMPSON: Yes.

13 MR. FRAWLEY: They all followed suit. And
14 you were able to do that without, certainly, sacrificing
15 your cost? In no instance did you get below cost?

16 MR. THOMPSON: Mr. Frawley, I am sure it is
17 obvious to you that when the price is reduced the total
18 income of my company is reduced and the fact that we can
19 do that, the remaining income is proportionately also
20 reduced because my manufacturing costs do not change as
21 abruptly as the price does and so the ability that our
22 company has to produce additional new drugs -- and we are
23 currently introducing a new tranquilizer -- our ability
24 to do these things is inhibited by the reduced income.

25 We have, I think, a very unhealthy situation
26 in which we are forced to choose on the one hand between
27 suffering a price disadvantage and calculating whether we
28 will be able to stay in business at our higher price and
29 so to take a higher income with which to do other things,
30 or to meet the competition and inhibit our ability to



1 introduce new drugs. We face such a decision.

2 MR. FRAWLEY: Mr. Thompson that is a very
3 interesting attitude. Obviously when you reduced these
4 antibiotics you did it without your profit position
5 suffering, but you did reduce your revenue. That is, your
6 gross revenue. That is obvious.

7 MR. THOMPSON: Mr. Frawley, there wasn't
8 very much profit left to suffer so we had to reduce our
9 promotion activities.

10 MR. FRAWLEY: Now then, you have passed on the
11 cost of that ---

12 THE CHAIRMAN: One question that perhaps
13 arises out of that, and we might just as well have it on
14 the record: When you reduce prices in that way, is there
15 any effect on your sales?

16 MR. THOMPSON: Well Mr. Chairman, talking
17 about the two instances I have referred to, there wasn't
18 enough -- the price differential did not exist for a
19 sufficient number of hours for any difference to develop.

20 THE CHAIRMAN: The market generally is
21 pretty unelastic?

22 MR. THOMPSON: No, I don't that necessarily
23 follows. The competitors followed so quickly ---

24 THE CHAIRMAN: After a reduction in price
25 would that lead to a considerable increase on sales? You
26 might have benefitted on the sales?

27 MR. THOMPSON: No. The reduction in price
28 -- if the advantage -- if I had been able to retain an
29 advantage for any length of time, certainly I would have
30 benefitted. I could have taken business away from my



1 competitors. They did not permit this to happen. They
2 met my prices so fast there was no period during which that
3 could occur.

4 THE CHAIRMAN: That is what I was getting
5 at. It is an unelastic market. Reduction of the price
6 does not cause a big increase in sales?

7 MR. THOMPSON: In the case of our company,
8 our total number of antibiotic doses in the past couple
9 of years has remained approximately constant.

10 MR. FRAWLEY: You say that your competitor
11 met your reduction so quickly that you did not get a chance
12 to bring in greater volume?

13 MR. THOMPSON: From them, yes.

14 MR. FRAWLEY: Well now, that doesn't make
15 what you did any less commendable though Mr. Thompson
16 because the price to the public went down not only on your
17 drug but on your competitors' products?

18 MR. THOMPSON: I have no regrets Mr. Frawley.

19 MR. FRAWLEY: Now then, you did say that
20 you always have to make this decision, whether you will
21 make a reduction in price which means some reduction in
22 revenue, or you will withhold the reduction in price so that
23 you can use your revenue and do certain things and you
24 mentioned the case of introducing a new tranquilizer.

25 MR. THOMPSON: Yes.

26 MR. FRAWLEY: Well now without philosophizing
27 too much about it, you do always -- and I say that very
28 sincerely -- you have the public good in mind in operating
29 your business Mr. Thompson?

30 MR. THOMPSON: Mr. Frawley I think that



1 competition, which is always at the root of these decisions,
2 works in the public interest. I think that this is the
3 philosophy under which our company -- country functions
4 and I am happy to live with that philosophy.

5 MR. FRAWLEY: So this interesting problem
6 that you pose for yourself is whether you should keep your
7 money and use it on introducing -- when you say introducing
8 a new drug that means more promotion, more samples and
9 that sort of thing.

10 MR. THOMPSON: It may mean another Aureomycin.

11 MR. FRAWLEY: No, but you said--you were
12 getting over into the tranquilizers, if I understood your
13 answer, you said we were thinking of bringing out a new
14 product, a new tranquilizer so you have to decide whether
15 by making a reduction in antibiotics you will give up
16 revenue, or you can refrain from promoting a new
17 product?

18 MR. THOMPSON: Yes, that is true. It is through
19 those decisions that products of the calibre of
20 Aureomycin, which I suggest was a revolutionary drug -- come
21 on the market in the first place, or a preparation like
22 Oral Polio Vaccine and any new drug that comes on the market
23 through these decisions, yes.

24 MR. FRAWLEY: And you think it is better to
25 put another tranquilizer on the market than to reduce the
26 price? Putting another tranquilizer on the market obviously
27 would not be for the purpose of reducing the price of
28 tranquilizers.

29 MR. THOMPSON: Mr. Frawley, I did not say
30 that I put a new tranquilizer on the market at the expense



1 of a price reduction on the antibiotics.

2 MR. FRAWLEY: I thought you did.

3 MR. THOMPSON: No.

4 MR. FRAWLEY: So I am glad to have you
5 correct me.

6 MR. THOMPSON: I am sorry, I said that I
7 have the choice of attempting to sell my antibiotics at a
8 higher price than my competitor. I have the freedom to
9 make this decision. His product is, let us say, ten per
10 cent lower than mine. I can say to myself that I think I
11 can still sell my product ten per cent higher and the
12 extra income will be used to launch a tranquilizer but I
13 find from the effect of competition that I cannot do that.
14 I could not maintain my sales against ten per cent
15 differential even if I spent the entire ten per cent on
16 promotion so I have no choice. I have to reduce my price
17 to meet the competitive level and still find some other
18 way to market my tranquilizer. Usually this means a
19 capital investment, if you will rather than promote it out
20 of income.

21 MR. FRAWLEY: Again reverting to the --
22 you said you did not like the word "rigidity" -- some
23 word that is equivalent, again looking at these prices,
24 this list of prices I quoted in this magazine, I gave you
25 the price to the wholesaler which was exactly the same,
26 \$25.24, and the price to the retailer was exactly the same
27 \$30.60 for each of those products, Achromycin, Polycycline,
28 Tetracyclin, Steclin -- does it strike you strange that those
29 prices would all be the same? Doesn't that rather ---

30 MR. THOMPSON: What do you mean?



1 MR. FRAWLEY: --deny the absence of price
2 competition in the market?

3 MR. THOMPSON: Mr. Frawley you are speaking
4 about the United States and I feel more comfortable talking
5 about Canadian figures which are not the same as those.

6 MR. FRAWLEY: Let me clear that up then
7 right now. All these products are sold in Canada, are
8 they not? Achromycin by Lederle; Polycycline by Bristol;
9 Tetracyn by Pfizer and Steclin by Squibb.

10 MR. THOMPSON: Have you heard of Polycycline?
11 I don't know ---

12 MR. FRAWLEY: Bristol's Polycycline, very
13 well known drug. I have bought it myself. It is known
14 in United States.

15 MR. THOMPSON: We know it by a different
16 name up here.

17 MR. FRAWLEY: And they are all Tetracycline
18 U.S.P. They wouldn't be Tetracycline U.S.P. in Canada would
19 they?

20 MR. THOMPSON: We don't use U.S.P. in Canada.
21 There is only one product that is put up in a soft
22 elastic capsule, and they are not all the same for that
23 reason. There is a difference right there that I think
24 may well be significant. If you suggest that these
25 products are all identical, I find it hard to agree with
26 you.

27 MR. FRAWLEY: You cannot agree that they are
28 identical?

29 MR. THOMPSON: No.

30 MR. FRAWLEY: This man shouldn't be calling



1 them all Tetracycline U.S.P. then?

2 MR. THOMPSON: They may contain tetracycline
3 but the availability of that drug to the patient is not
4 necessarily described by that.

5 MR. FRAWLEY: I don't quite know what that
6 means. The "availability to the patient" is what?

7 MR. THOMPSON: The physiological, the
8 availability of the drug Mr. Frawley, varies according to
9 the way it is prepared in the dosage form. They may all
10 contain the same drug.

11 MR. FRAWLEY: This man has called these
12 four products Tetracycline U.S.P. I am only asking the
13 question. I just don't know. Are they all listed on the
14 Canadian market at some price?

15 MR. THOMPSON: I don't know Polycycline.

16 MR. FRAWLEY: Just eliminating that,
17 Achromycin, Tetracyn and Steclin ---

18 MR. THOMPSON: Yes, I believe they are the
19 same price, Mr. Frawley.

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1 MR. FRAWLEY: Would it be a fact that
2 Lederle is American-owned, basically?

3 MR. THOMPSON: Yes.

4 MR. FRAWLEY: So is Bristol.

5 MR. THOMPSON: Yes.

6 MR. FRAWLEY: So is Pfizer.

7 MR. THOMPSON: Yes.

8 MR. FRAWLEY: So is Squibb?

9 MR. THOMPSON: Yes.

10 MR. FRAWLEY: Would you think the fact they
11 are all put on the market in the United States at the
12 same price has something to do with these companies all
13 listing on the Canadian market at the same price?

14 MR. THOMPSON: They are not listed in
15 Canada at the same price as in the United States.

16 MR. FRAWLEY: No, no. At a different price,
17 but at the same price, each company puts it on the market
18 at the same price, Canadian Lederle, Canadian Bristol,
19 Canadian Pfizer, Canadian Squibb puts tetracyclines on
20 the market at the same list.

21 MR. THOMPSON: What is your question, Mr.
22 Frawley, I am sorry?

23 MR. FRAWLEY: My question simply, is there
24 anything suggested in the fact they are all owned in the
25 United States, we find the four companies in the United
26 States having the same list to the retailer and Canada as
27 having the same list to the retailer although the two
28 prices may be different.

29 MR. THOMPSON: It seems to me the two
30 companies have responded to the same competitive pressures



1 in those companies. I don't see why it should be surprising
2 that that sets rates in the U.S. and shouldn't in Canada.

3 MR. FRAWLEY: That is just the question,
4 isn't it? To the ordinary person buying the drugs they
5 wouldn't think there was much competition when they find
6 they are listed to the retailer at \$30.60, right down even
7 to the last cent.

8 MR. THOMPSON: Mr. Frawley ---

9 MR. FRAWLEY: \$30.60. It may just an acci-
10 dent, it may indicate real competition, but some people
11 might suggest that indicates the absence of competition.

12 MR. THOMPSON: The time I would worry is if
13 the differential in prices remained in variation for any
14 appreciable length of time because if I could remain in
15 the market at a higher price than Squibb or Pfizer and
16 retain my sales volume for a substantial period of time I
17 suggest to you that would be evidence that the market is
18 not price conscious, price competition is not accepted.

19 MR. FRAWLEY: Mr. Thompson...

20 MR. THOMPSON: When I am forced to my compe-
21 titors' price or when they are forced to mine, that is
22 what has happened, the situation I have described to you.
23 I suggest to you that is the best evidence there is compe-
24 tition. I suggest to you that is the best evidence there
25 is competition because it is the kind of thing that pro-
26 duces the same price in fuel and gasoline or bread.

27 MR. FRAWLEY: Lederle's cost would not be
28 identical with Squibb's cost, Lederle's cost of making
29 Achromycin must vary from Pfizer's Steclin.

30 MR. THOMPSON: Mr. Frawley, I can't tell you.



1 I don't know.

2 MR. FRAWLEY: It would be a remarkable
3 coincidence, wouldn't it be, if these four products cost
4 to the cent exactly the same in each plant.

5 We will leave that. Let's go to another one.
6 Let us go to Triamcinolone. There are only two of those,
7 Lederle's Aristocort and Squibb's Kenacort. I find in the
8 United States and you can tell me what the situation is in
9 Canada, the case of Lederle's Aristocort is \$17.19. You
10 wouldn't be surprised that the price of Squibb's Kenacort
11 is \$17.19. In Canada it may not be \$17.19, but whatever
12 it is it is the same, Mr. Thompson?

13 MR. THOMPSON: I don't believe they are the
14 same, but they are very close. They are very close.

15 MR. FRAWLEY: They would be so close that I
16 imagine the person coming in with the prescription would
17 pay the same?

18 MR. THOMPSON: I am sorry?

19 MR. FRAWLEY: If the list was close enough,
20 within a few cents, the patient with the prescription
21 would probably have the price rounded out so he would pay
22 the same.

23 MR. THOMPSON: I would expect the price to
24 the patient would be, would depend on the cost of the
25 druggist who would sell.

26 MR. FRAWLEY: It would be list minus 40%
27 that is generally standard on consumer prices. The cost
28 to the retailer would be, the cost of these to the patient
29 with the prescription would be \$17.19 plus his markup,
30 which in this country is 40%. Again I simply leave it to



1 you that way. There is nothing ulterior about my question.
2 It just seems to be something that requires some explana-
3 tion, maybe an excellent explanation, an obvious one, but
4 when you find these products identical...

5 MR. THOMPSON: Mr. Frawley, I suppose...

6 MR. FRAWLEY: In price.

7 MR. THOMPSON: I assume you are aware that
8 Triamcinolone, by whatever manufacture, has to compete with
9 other steroid drugs such as Betamethasone, Dexamethasone,
10 Meticorten and Meticortilone - I could name another dozen,
11 all of which are suitable for the same general type of
12 disease and subject to the physician's choice. In other
13 words the physician has to compare what Trancinilone would
14 do at Betamethasone prices, what Betamethasone might do
15 for that patient at whatever price it may be, and the
16 shifting pattern of sales volume reflects these decisions
17 made by physicians all the time. Therefore the general
18 pricing level of Trancinilone, whether one company, two
19 or ten is not an independent affair.

20 MR. FRAWLEY: I take it that you would agree
21 that the pricing of drugs, cost of drugs bears little or
22 no relation to the expense of their production.

23 MR. THOMPSON: The cost of the drugs bears
24 little or no --?

25 THE CHAIRMAN: The cost or selling price?

26 MR. FRAWLEY: The selling price.

27 MR. THOMPSON: I think there is a very
28 considerable relationship. It depends to some extent what
29 you mean by cost, Mr. Frawley.

30 MR. FRAWLEY: Let me read you this. A



1 gentleman by the name of Condor who, I think, is Mr.
2 Hume's client, wrote something on Applied Therapeutics
3 which my people in Edmonton sent me telling me I should
4 read it. It is called Cost of Drugs. This is what a
5 gentleman wrote to the editor about Applied Therapeutics
6 and Mr. Condor's article:

7 "Mr. Condor is an expert and practised
8 apologist for the drug manufacturing
9 industry, but some of his statements in
10 the article on the Cost of Drugs in the
11 July issue of your journal need to be
12 challenged. I, for one, do not feel the
13 "sense of bewilderment" you describe in
14 your editorial comment in relation to
15 this problem, for I think the issue is
16 clear.

17 The fact is that there has been a suppres-
18 sion of price competition to such an extent
19 that the cost of drugs bears no relationship
20 to the expense of their production. CHLORAM-
21 PHENICOL, ERYTHROMYCIN, TETRACYCLINE,
22 DEMETHYLCHLORTETRACYCLINE and the whole
23 list of useful broad-spectrum antibiotics
24 all cost virtually identical amounts. Who
25 will be prepared to argue that these drugs,
26 some new and some old, all cost the same
27 to produce? Who will deny that this repre-
28 sents price-fixing by the industry?"

29 VOICES: I would.

30 MR. FRAWLEY: I imagined there were lots of



1 people that would. I will finish reading the letter:

2 "Those of us who believe in our capitalistic
3 system surely will not deny the drug
4 industry its fair reward for the efforts
5 and risks described by Mr. Condor. However,
6 any attempt to subvert the 'judgment of
7 the market-place' must surely bring with
8 it the government interference and general
9 condemnation that we are now witnessing.

10 Norman C. Kerbel, Toronto"

11 THE CHAIRMAN: Have you any information
12 about Mr. Kerbel?

13 MR. FRAWLEY: As far as I am concerned he
14 is just a writer to the editor.

15 THE CHAIRMAN: The only value it would have
16 to us is if it is expert evidence or opinion.

17 MR. FRAWLEY: I am putting it to you that
18 the identity of the list prices which is what it amounts
19 to, I suggest to you, Mr. Thompson, makes one wonder if
20 there is really price competition. I am only thinking
21 about price competition, not competition of one drug
22 against the other in its therapeutic value, just price
23 competition. I suggest to you the record makes one wonder
24 if there is any great deal of price competition?

25 MR. THOMPSON: Mr. Frawley I will try to
26 answer your question. I think I understand what you are
27 driving at in a different way. I am sorry I haven't got
28 with me to show you the sales aid which our company has
29 furnished for salesmen in interviews with physicians to
30 demonstrate to them the economic advantage of using



1 Declomycin which you suggest is identically priced. I
2 would like to remind you the dosage is different. It has
3 a different chemical substance that reacts in a different
4 way. The same number of capsules will treat a patient
5 for a longer period of time, which is an effective economic
6 advantage of this particular drug. I wish I could show
7 you the sales aid which our representatives carry to show
8 the physicians how these advantages work for the benefit
9 of the patient in lowering the cost of treatment with
10 Declomycin. If you think there isn't price competition
11 in the industry I wish you could travel for a few days
12 interviewing physicians as my colleagues do. I can assure
13 you that would rapidly change your views. We find physi-
14 cians exceedingly interested in prices, exceedingly
15 interested in the economy of treatment.

16 THE CHAIRMAN: It's nearly 5 o'clock, well
17 past our usual closing time.

18 MR. FRAWLEY: I thought you generally
19 recessed at half-past-four. I thought you would have
20 stopped me long ago.

21 THE CHAIRMAN: I thought you had better
22 finish the line of questioning.

23 We will adjourn until tomorrow morning at
24 10 a.m.

25
26 Miss M. Reeves and Mrs. E.M. Thorburn sworn as Official
27 Reporters by the Chairman.

28
29 --- Whereupon the hearing adjourned until 10 a.m.,
30 Tuesday, October 17th, 1961.



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

1
2
3 INQUIRY UNDER SECTION 42
4 OF THE COMBINES INVESTIGATION ACT

5
6 Relating to the manufacture, distribution and sale
7 of drugs

8
9 By Director of Investigation and Research
10 Combines Investigation Act

11 COMMISSION:

12
13 C. RHODES SMITH, Q.C. -- Chairman
14 A. S. WHITELEY, M.A. Member of the
15 Commission
16 PIERRE CARIGNAN, Q.C. Member of the
17 Commission
18 F. N. MacLEOD Combines Officer,
19 representing the Director of Investigation
20 and Research

21 Proceedings of hearings commencing at
22 10.10 a.m. Tuesday, October 17th, 1961,
23 et seq in the City of Toronto, in the
24 Province of Ontario.
25
26
27
28
29
30



Toronto, Ontario,
October 17th, 1961.

1
2 --- On commencing at 10.10 a.m.

3 THE CHAIRMAN: We will resume the hearing,
4 gentlemen. Mr. Frawley, you were questioning Mr. Thomp-
5 son.

6 MR. THOMPSON (recalled)

7 MR. FRAWLEY: Mr. Thompson, yesterday I
8 was speaking to you about the schedule of prices in the
9 magazine called "Changing Times" for August 1960, and I
10 wanted to call your attention this morning to something
11 else and ask you if you agree, and perhaps tell me why.

12 Referring to the matter of prescribing and
13 buying by generic names rather than brand names, I find
14 that in this statement in the case of tetracycline U.S.P.
15 which I told you yesterday was broken down into the brand
16 names of Lederle's Achromycin, Bristol's Polycycline,
17 Pfizer's Tetracyn, Squibb's Steclin and Upjohn's Panmycin.
18 There is a note here that the price range, the consumer
19 price range for these drugs without brand names cannot be
20 given because there are no other sellers.

21 Then, before I ask you to reply, let me tell
22 you also that in the case of triamcinolone, which is your
23 Lederle's Aristocort and Squibb's Kenacort, again there
24 is no price shown for the consumer in buying the drug
25 without brand name because the notation is "No other
26 sellers".

27 And then just one more: in the case of the
28 steroid, dexamethasone which is Merck's Decadron, again,
29 "There are no other sellers". So that it is not open to
30 the patient or the doctor prescribing the prescription to



1 prescribe these drugs by brand name. Would you care to
2 comment on that? I said that wrongly - to prescribe
3 these drugs by generic name.

4 MR. THOMPSON: Mr. Frawley, it seems to me
5 that you are being misled by the note, "No other sellers"
6 because you have described - you have mentioned triamci-
7 nolone. You have mentioned dexamethasone. These drugs
8 are very similar in their application and the physician
9 actually has a choice which is not revealed and which
10 the author of that article apparently does not understand.
11 So that I suggest to you that there is in fact a choice
12 open to the physician.

13 MR. FRAWLEY: All right, so he has a choice,
14 the physician has a choice in prescribing triamcinolone
15 and dexamethasone. Do you say they are interchangeable?

16 MR. THOMPSON: They may be interchangeable.
17 Those are different entities, different drugs with
18 differing properties, but directed at the same general
19 disease states.

20 MR. FRAWLEY: I know a little something about
21 Decadron because this has been prescribed for myself, and
22 I know something about Aristocort because it has been
23 prescribed for my wife, and I put it to you that those are
24 not completely interchangeable.

25 MR. THOMPSON: No, Mr. Frawley, I don't
26 think I said they are.

27 MR. FRAWLEY: I simply put it to you, that
28 if the physician prescribed triamcinolone - and I want to
29 tell you that that is precisely what my wife's consultant
30 did, on one prescription, and then he wrote under that



1 "Aristocort", what does that add up to? That is all that
2 is troubling me.

3 MR. THOMPSON: It suggests that the physician
4 had a good deal of confidence in Aristocort, and I am very
5 pleased to know that that happened.

6 MR. FRAWLEY: That is not so, and I certainly
7 did not ask the question to be led into a little more
8 publicity for Lederle. I just want to know what would
9 have happened if he had simply written "triamcinolone" and
10 had not put in brackets under it "Aristocort" which meant
11 Lederle right away?

12 MR. THOMPSON: He would put the druggist in
13 the difficult position of having to choose between a
14 product made by Lederle and a product made by Squibb.

15 MR. FRAWLEY: So that in that case the
16 druggist would simply have chosen either Squibb's Kenacort
17 or Lederle's Aristocort, bottled and labelled and packaged
18 it for these people and not a generic drug purchased and
19 sold as such?

20 MR. THOMPSON: Yes, indeed. He would have
21 been so instructed by the physician.

22 MR. FRAWLEY: So that in those cases that
23 I have given you, you say I was misled by the words "No
24 other sellers"? I put it to you that - and I would like
25 to be precise in my language - I won't say a "closed shop",
26 but there just is not any possibility of getting it under
27 a true generic name.

28 MR. THOMPSON: Mr. Frawley, these products
29 are labelled in every case in the generic name on the
30 label. This in fact is what the pharmacist is supplying.



1 MR. FRAWLEY: Why bother to put "Aristocort"
2 on it at all, why not just the term, "triamcinolone U.S.P."?

3 MR. THOMPSON: There is an excellent reason
4 for that, Mr. Frawley. You are putting your finger on
5 the basic motivating forces of the free enterprise system
6 when you ask that question, and I am very glad it came up.

7 I will give you again, Mr. Frawley, the
8 example that I have in my hand that I gave yesterday.
9 This is calcium carbimide, tablets, by the generic name.
10 Anybody, yourself included, could buy this drug in the
11 open market at a very low figure because, as I think I
12 mentioned yesterday, it is made by the hundreds of thou-
13 sands of tons each year. You could formulate tablets and
14 you could very probably eliminate the contaminating cyanides
15 which are present in the agricultural product, and make
16 it safe for human consumption, and market it with the name
17 "Calcium Carbimide tablets". The only trouble is, that
18 nobody would order your product because physicians don't
19 understand it and don't have confidence in it.

20 I suggest to you that you would have no sale
21 for that product. You would be all dressed up with no
22 place to go in terms of this particular preparation.

23 THE CHAIRMAN: I thought yesterday you said
24 there was not very much of a market even ---

25 MR. THOMPSON: I beg your pardon?

26 THE CHAIRMAN: I thought yesterday you said
27 there was not very much of a market even for it under the
28 trade name.

29 MR. THOMPSON: Yes, Mr. Chairman, and the
30 reason is the same. The confidence of the physician has



1 not been earned for this product. It has not been pro-
2 moted. Nobody as yet has promoted this product to any
3 marked extent.

4 Now, under that generic name system, who
5 will promote the product? Who will bring it into use?
6 As I think I said, this has been recommended very highly
7 in the Canadian Medical Association Journal. The best
8 advice that my colleagues can get is that this is a good
9 drug. Triamcinolone is a similar situation, and who
10 should promote it? Should I promote it and have you fill
11 the demand?

12 MR. FRAWLEY: If I might say so, with every
13 respect, I think you are obsessed with the idea of promo-
14 tion. Let me put it this way: take the case of a competent
15 allergist anywhere in Canada. He knows something about
16 triamcinolone and knows what it will do, and dexamethasone
17 and knows what it will do. Why does he have to have some
18 promotion to him? He simply writes the prescription
19 "triamcinolone, such a strength" on a prescription as to
20 the dosage, and the patient takes it to the drugstore and
21 presents it to the pharmacist.

22 MR. THOMPSON: You have made the assumption,
23 Mr. Frawley, that the allergist knows about triamcinolone.
24 As I think I showed you, we had to accumulate 1,200 pages
25 of technical data on that product before it could be
26 marketed. How do you suppose that the allergist comes to
27 know about triamcinolone?

28 MR. FRAWLEY: Well now, Mr. Thompson, I
29 wonder how he does. Are the drug houses educating the
30 physicians or the medical colleges?



1 MR. THOMPSON: There are two kinds of
2 medical education. There is the basic type of education
3 in the sciences such as pathology which is rightfully the
4 role of the medical college. The medical college is not
5 able to educate a physician on a drug which comes on the
6 market after the medical college, and the physician, have
7 parted company, and someone else has to do this.

8 MR. FRAWLEY: You are not telling me,
9 surely, that this consultant that prescribed triamcinolone
10 for an eczema condition of my wife did not know anything
11 about this until Lederle told him about Aristocort. Are
12 you telling me he didn't know that triamcinolone and its
13 basic properties was the thing to remove that very distur-
14 bing condition?

15 MR. THOMPSON: That is exactly what I am
16 attempting to say.

17 MR. FRAWLEY: That is what you are attempting
18 to say?

19 MR. THOMPSON: Yes indeed, unless he was an
20 unusual consultant.

21 MR. FRAWLEY: He is a specialist. He is an
22 allergist and I put it to you in all seriousness that he
23 knows all about triamcinolone and what it will do basically.

24 MR. THOMPSON: Where did he find out, Mr.
25 Frawley?

26 MR. FRAWLEY: I hope he found out from his
27 medical education and reading the information in promo-
28 tional journals like the journal of the American Medical
29 Association and its Canadian counterpart and the journal
30 of the Society of Allergists, or whatever their name is.



1 Surely he didn't have to depend upon Lederle's promotion
2 literature?

3 MR. THOMPSON: Then we don't have to promote
4 the product.

5 MR. FRAWLEY: I didn't hear you.

6 MR. THOMPSON: In that case we would not
7 have to promote the product, and I wish you were right,
8 but the evidence I have seen in my years in the industry
9 is there is a vast difference between announcing the
10 availability of the drug of a particular use, and the
11 confidence of the physician in the drug.

12 MR. FRAWLEY: You told me that similarly
13 dexamethasone, you say these men who are treating these
14 conditions, arthritic conditions of many varieties, that
15 they are not aware that dexamethasone is the thing that
16 will reduce inflammation quickly, but they have to wait
17 until they hear what Merck says about Decadron and what
18 Schering says about Deronil and what Ciba's Gammacorten.

19 MR. THOMPSON: If the activities I have
20 described, communication with the doctor through promotion,
21 were not an effective means of treatment, this would be
22 eliminated by competitive inter-play very promptly. I
23 showed you a package of Cellothyl yesterday. Promotion
24 of this product stopped because it ceased to be effective.
25 It ceased to have meaning for the physician.

26 MR. FRAWLEY: I think you told me yesterday,
27 and I certainly want to complete this questioning as
28 expeditiously as I can, if one looks at the retail price
29 lists, we will find Lederle's Aureomycin, Parke, Davis'
30 Chloromycetin, Pfizer's Terramycin, Lederle's Achromycin,



1 all listed at the same price.

2 MR. THOMPSON: We will, in the United States,
3 Mr. Frawley, and you probably will in Canada too. My
4 company does what it can to make that identity exist, and
5 I would be rather frightened if it didn't exist.

6 THE CHAIRMAN: I think perhaps in view of
7 the nature of our Statute, you might like to modify that
8 statement a little bit because someone might think you
9 got together with your competition.

10 MR. THOMPSON: I would be glad to clarify
11 that. When my competitor establishes a new product, I
12 very promptly improve it in order to obtain my share of
13 the market, just as the evidence indicates had been done
14 when we lowered our price and were followed by our compe-
15 titors last Fall.

16 MR. FRAWLEY: Let us look at a little
17 different aspect of this. In the Green Book on page 173
18 we have reference to Declomycin, and it shows a list
19 price of \$56.61 per hundred. That might have been reduced
20 since the end of 1959 when the Green Book price lists were
21 effective. I think you told us yesterday that it was
22 \$40.25. Am I right about that? Did you give us the list
23 on Declomycin yesterday?

24 MR. THOMPSON: Yes I believe I gave you
25 \$43.13.

26 MR. FRAWLEY: \$43.13. You certainly gave
27 that for Achromycin. Declomycin is the same price?

28 MR. THOMPSON: Yes.

29 MR. FRAWLEY: We come back to this all the
30 time. All of your antibiotics are put in at the same



1 price, and the varying cost factors simply do not operate.

2 Is that the situation, Mr. Thompson?

3 MR. THOMPSON: No, I don't think I said that,
4 Mr. Frawley.

5 MR. FRAWLEY: You may not have said that,
3 6 but I am putting it to you, if you are charging or listing
7 all of your antibiotics, your newest and your oldest, your
8 volume seller or your small seller, all the same, I say
9 that the cost factor is not properly operating.

10 MR. THOMPSON: Mr. Frawley, it depends on
11 how you define cost. If you define the cost as the simple
12 measure just of the cost of putting the drug in a package,
13 putting it on the shelf, you very definitely have a
14 variable factor. As I told you yesterday, as the sales
15 volume of Aureomycin declines, the cost of producing a
16 package presses upwards.

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1 MR. FRAWLEY: Why? Why do you say that?

2 MR. THOMPSON: If you have ever purchased
3 cartons you would see what I mean, because the price
4 depends on the quantity.

5 MR. FRAWLEY: Of course that is why I
6 suggest to you - well, I am going to suggest something
7 else in a few minutes.

8 MR. THOMPSON: I would like to continue
9 answering your question.

10 MR. FRAWLEY: Yes, indeed. I haven't
11 really asked my question. \$43.13, according to your
12 price on page 16, is the list price of Achromycin, and
13 you are telling me that it is the same for Declomycin.
14 Now, I found that Starkman, who are acknowledged Lederle
15 distributors apparently ---

16 MR. THOMPSON: He is a customer. He is
17 legally entitled to buy drugs, and therefore he is a
18 customer.

19 MR. FRAWLEY: You say he is a customer?
20 Every retail drugstore in Canada is a customer of Lederle?

21 MR. THOMPSON: Starkman is a retail customer.

22 MR. FRAWLEY: Is Starkman a retail druggist?

23 MR. THOMPSON: Yes, indeed.

24 MR. FRAWLEY: Let's look at some of his
25 prices. Starkman advertises Declomycin capsules of 150
26 milligram strength in bottles of 100 at \$28.73, and that
27 is after the doctor's discount of 40% has been taken off,
28 so the list would be \$40.25? Then Starkman's list would
29 be \$40.25. You tell us there it is \$43.13, and I wonder
30 if you would just reconcile that, and before you do, I



1 will give you two other of the Lederle products we have
2 been speaking about, Achromycin capsules of 250-milligram
3 strength in bottles of 100; Starkman advertises it at
4 \$28.73, but of course the discount has been taken off,
5 so that the list would be \$28.73 plus 40%. Starkman's
6 list would be again \$40.25.

7 Now, would you reconcile that difference
8 such as it is between what Starkman's list is - if you
9 say he is just an ordinary drugstore - than what
10 Tamblyn's list would be?

11 MR. THOMPSON: First, Mr. Frawley, I would
12 have to say Starkman buys on the same terms from our
13 company as any other retail account, and our selling
14 prices are determined by a suggested list price which is
15 the price that our company sets, and from which discounts
16 are calculated.

17 Mr. Starkman then has a cost with which he
18 can do as he pleases. He is a customer of ours. It
19 would not be proper for us to attempt to influence his
20 retail price, and he publishes the list that you have
21 apparently found at his own behest. It is his privilege
22 to do so, and I don't think it would be proper for me to
23 explain how Starkman sets his selling prices.

24 MR. FRAWLEY: No, no.

25 MR. THOMPSON: I can tell you something
26 about Starkman's costs, which is the only factor that our
27 company influences.

28 MR. FRAWLEY: I am just pointing out what
29 is written in his book, on the inside back cover of his
30 catalogue. \$28.73 for a total of 100 Declomycin capsules,



1 and he advertises doctor's discount, 40%, so it is a
2 matter of arithmetic on my part. You have your slide rule,
3 and perhaps you can correct my arithmetic. I worked it
4 out laboriously to \$40.25.

5 MR. WAHN: Mr. Chairman, I think the witness
6 has indicated that the discount is taken off the suggested
7 list price.

8 MR. THOMPSON: That is correct, Mr. Wahn.
9 I was just going to say that.

10 MR. WAHN: I am sorry.

11 THE CHAIRMAN: In order to have the record
12 clear, Mr. Thompson might tell us in what area Starkman
13 operates. What area of Canada?

14 MR. THOMPSON: I am not sure, Mr. Chairman.
15 Starkman operates a very excellent retail pharmacy in
16 Toronto.

17 THE CHAIRMAN: Just one store?

18 MR. THOMPSON: I am not sure. I believe
19 that they have been interested in extending their activi-
20 ties beyond just the Toronto area. I believe they started
21 by operating a city-wide delivery service, for example,
22 from a single store, and they have since engaged in
23 publishing a catalogue, and I believe Mr. Frawley is
24 looking at the same one I have seen. This suggests to me
25 they are interested in expanding their business, and I
26 think they have a very good business.

27 THE CHAIRMAN: When I asked the question,
28 ordinarily a retail pharmacist does not get out a big
29 catalogue of that kind to operate from one store unless it
30 is a very big store. I would think it would be something



1 in the nature of a chain operation or at any rate an
2 operation which has a number of locations.

3 MR. FRAWLEY: Let's not be under any misap-
4 prehension. When you said he was an ordinary retail drug-
5 store you mean he was an ordinary retail drugstore opera-
6 ting at 459 Bloor Street West, Toronto?

7 MR. THOMPSON: I believe Mr. Starkman's
8 business is a retail drug account by the standards of our
9 company. He buys what we call a trade class 43 account.
10 This is the means by which we seek to treat all customers
11 equally, and the discount that Mr. Starkman's business
12 earns on our products depends on the trade class, TC43,
13 as we call his classification, under which this business
14 falls. I might add the selling price to wholesalers is
15 just the same.

16 MR. FRAWLEY: Of course I suppose you are
17 not very much concerned with your customers because you
18 have them all over Canada, but I wouldn't want to be
19 under any misapprehension in the way, in the extent to
20 which this man Starkman operates his business. I have
21 here a bill of goods that he sold to a doctor in Edmonton,
22 Alberta, on July 3, and it all adds up to something over
23 \$400.

24 Now, I don't know of any corner drugstore in
25 Toronto that is reaching out, selling doctors in Edmonton.

26 MR. THOMPSON: I admire Mr. Starkman's
27 enterprise, and I am glad he is able to do that, Mr.
28 Frawley. I am not surprised.

29 MR. FRAWLEY: But he does get a little better
30 list than the corner drugstore?



1 MR. THOMPSON: Well, Mr. Frawley, may we
2 just review the method of using list prices? Our company
3 publishes a list price, and this list price is the star-
4 ting point from which a discount is applied. The discount
5 that Mr. Starkman would earn is 40%, so we would start
6 with a list price and deduct 40%.

7 MR. FRAWLEY: That is right.

8 MR. THOMPSON: And we would arrive I think
9 you said at \$28.73.

10 MR. FRAWLEY: That is right.

11 MR. THOMPSON: Now, we would not start with
12 \$28.73 and add 40% on that.

13 MR. FRAWLEY: That is quite correct. This
14 is the end result after he has taken off the doctor's
15 discount of 40%, but you, having a slide rule, you can
16 do it both ways. Take \$40.25, and take 40% from that.

17 MR. THOMPSON: \$40.25, and take off 40%?
18 I would get about \$24.20 on my slide rule, Mr. Frawley.

19 MR. FRAWLEY: That is pretty bad. Take
20 \$28.73 and add 40%.

21 MR. THOMPSON: That is what I would have to
22 do. This has to be approximate. I would get something
23 between \$46 and \$47 as the list price.

24 MR. FRAWLEY: So that what you say is then
25 he is paying about \$46 to Lederle for this Declomycin?

26 MR. THOMPSON: Well, I would say that he is
27 publishing on the basis of a list price of that amount.
28 Somewhat over \$46.

29 MR. WAHN: Mr. Chairman, I would like to
30 qualify that. This is not the price that you charge Mr.



1 Starkman?

2 MR. THOMPSON: No. This is the price that
3 Mr. Starkman has chosen to publish.

4 MR. FRAWLEY: What do you charge Mr. Stark-
5 man?

6 MR. THOMPSON: Mr. Starkman would now pay
7 \$25.88 sales tax included for that package.

8 MR. FRAWLEY: Mr. Starkman would pay \$25.88?

9 MR. THOMPSON: Per 100.

10 MR. FRAWLEY: Because he would pay \$43.13
11 less 40%.

12 MR. THOMPSON: Yes.

13 MR. FRAWLEY: Well, perhaps I had better
14 ask Mr. Starkman about these things.

15 MR. THOMPSON: He set the prices, Mr.
16 Frawley. I think that would be a good idea.

17 THE CHAIRMAN: Just to get this a little
18 clearer in my mind, does a druggist operating on a scale
19 of Mr. Starkman get any additional discount for volume
20 or anything of that sort, or is he exactly on the same
21 footing as any other retail druggist?

22 MR. THOMPSON: Under our philosophy of doing
23 business, he is on the same footing. We operate our own
24 distribution facilities in Canada, and sell from six loca-
25 tions in the country. Although at one time additional
26 discount was allowed to wholesalers, we came to the conclu-
27 sion that we could do business with good efficiency and
28 more economically by selling direct, and therefore we have
29 not encouraged distributors through an extra discount.

30 THE CHAIRMAN: All your customers are



1 commercial customers? Wholesalers or retailers, regard-
2 less of size or volume of purchase, get the same price?

3 MR. THOMPSON: On antibiotics, yes. There
4 is one qualification that will have to be made. We do
5 have an incentive which we call the Lederle Purchase Plan,
6 and under this plan a pharmacist, for example, can earn
7 an additional discount depending on the total size of the
8 order. This discount does not apply in general to the
9 prescription drugs.

10 He is unable in effect to influence the
11 sale. He merely acts as the professional dispenser, but
12 we have other preparations in our line, notably vitamin
13 products, where the pharmacist can encourage sale consi-
14 derably by displaying packages in his store, and by recom-
15 mending a product to a customer, and those products
16 generally are the subject of the additional discount
17 which increases with the size of the order. This is not
18 true, however, of the antibiotics. It is not true of
19 Aristocort.

20 THE CHAIRMAN: Tranquilizers?

21 MR. THOMPSON: That is correct. We are
22 introducing a new tranquilizer under the trade name of
23 Trepidone at the present time, and this is a prescription
24 item, and the purchase plan discount does not apply.

25 THE CHAIRMAN: It does not apply to the
26 prescription item?

27 MR. THOMPSON: No.

28 MR. WAHN: Perhaps it would be helpful to
29 the Commission and we would be quite prepared to file our
30 published printed list price. I don't know whether you



1 have a copy.

2 MR. THOMPSON: I believe we have done so,
3 but it wouldn't be up-to-date, with the Director of
4 Combines Investigation, but we would be very happy to.

5 MR. FRAWLEY: The effect of what you are
6 saying, Mr. Thompson, is that Mr. Starkman, who is selling
7 to doctors in Edmonton, is getting the same price from
8 Lederle ---

9 MR. THOMPSON: As the doctor would get.

10 MR. FRAWLEY: No, no, no. Starkman, buying
11 from Lederle, pays so much. X cents. Now, we know the
12 scope of his business. I have just shown you where he has
13 sold \$480.00, not only of drugs but surgical supplies and
14 all sorts of things. Does he not enjoy any better price
15 than a smaller neighbourhood drugstore, say like Astley's,
16 on Laurier Avenue West, in Ottawa?

17 MR. THOMPSON: No.

18 MR. FRAWLEY: So that he is reaching out and
19 selling to the doctors in Edmonton and he is paying the
20 same price that the little drugstore on the corner of
21 Laurier Avenue would pay?

22 MR. THOMPSON: He is also paying the same
23 price that the physician in Edmonton would pay if he
24 ordered from our depot in Calgary.

25 MR. FRAWLEY: The physician in Alberta would
26 pay your list less 40%?

27 MR. THOMPSON: Yes. The physician in Edmon-
28 ton can choose. He can buy from this Mr. Starkman who
29 would like to be apparently a distributor - it is a deci-
30 sion of his own - or the physician can order from the



1 Lederle depot in Calgary, and the physician buying
2 directly from the depot, from our depot, would pay the
3 same price that Starkman pays.

4 MR. FRAWLEY: Now, dealing with Achromycin,
5 250-milligram strength in hundreds for a moment, your
6 price indicates that your list is \$43.13, you have told
7 us about the price to Starkman which you say is \$43.13
8 less 40%. Now, Achromycin is Declomycin?

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C/MR/hm

1 MR. THOMPSON: Achromycin is a preparation,
2 contains tetracycline.

3 MR. FRAWLEY: Well yes, you list it in the
4 Vademecum as Achromycin Tetracycline, broad spectrum
5 antibiotics developed by Lederle Research.

6 MR. THOMPSON: The word "Achromycin" is
7 used as an adjective there Mr. Frawley, describing the
8 special preparation of tetracycline made by Lederle.

9 MR. FRAWLEY: I see. Well looking at the
10 heading of the drug, there are two headings, Achromycin,
11 Tetracycline, Lederle PR, meaning prescription drug?

12 MR. THOMPSON: Yes.

13 MR. FRAWLEY: Immediately under that
14 Achromycin you have Buffered Tetracycline Lederle.

15 MR. THOMPSON: Yes.

16 MR. FRAWLEY: And you don't pretend to call
17 it anything but Tetracycline?

18 MR. THOMPSON: I call it Tetracycline
19 Lederle, or I call it Achromycin because it is in fact
20 not pure tetracycline. It has to be prepared with
21 insipiens. It has to be put in dosage form capsule.

22 MR. FRAWLEY: I would like to call your
23 attention to what I find in this catalogue that you made
24 an exhibit yesterday, and I find Achromycin capsules 250
25 milligrams, and I am reading from page 25 of Gilbert's
26 Surgical News of May 1961 Achromycin capsules at 250
27 milligrams \$42.08 a hundred, and he has the price that you
28 have quoted of \$42.13. He doesn't say they are Lederle.
29 He simply calls them Achromycin capsules but Achromycin
30 is one of the Lederle trade names, isn't it?



1 MR. THOMPSON: Yes, it is.

2 MR. FRAWLEY: If I say that I have just
3 had some Achromycin prescribed for me, I tell to whomever
4 I am speaking that I have got a Lederle preparation?

5 MR. THOMPSON: Yes.

6 MR. FRAWLEY: No doubt about that.

7 MR. THOMPSON: You can be confident when
8 you say that.

9 MR. FRAWLEY: I can also be confident that
10 I have a good product.

11 MR. THOMPSON: Indeed.

12 MR. FRAWLEY: Now I find that Mr. Gilbert
13 advertises in the opposite column Tetracycline HCL buffered
14 capsules 250 milligrams \$18.00.

15 MR. THOMPSON: Yes, I am aware of that.

16 MR. FRAWLEY: Yes, it is foolish of me to
17 think you were not aware of it. You are perfectly well
18 aware of it.

19 MR. THOMPSON: What is your question, Mr.
20 Frawley?

21 MR. FRAWLEY: Now do you say that what Mr.
22 Gilbert is selling is not what you are selling at all?

23 MR. THOMPSON: Let's start about talking
24 about those two prices. You have referred to a price of
25 \$40.00 something, over \$40.00.

26 MR. FRAWLEY: \$42.08 he says is the price,
27 is the list for Achromycin capsules.

28 MR. THOMPSON: Does he say that is the list
29 price Mr. Frawley?

30 MR. FRAWLEY: He just says brand -- he calls



1 them -- I will give you his terminology, brand name drugs
2 at professional prices.

3 MR. THOMPSON: That does not refer to that
4 as a list price.

5 MR. FRAWLEY: I felt that it is a list
6 price.

7 MR. THOMPSON: Well then would the other
8 prices that you quoted also be a list price?

9 MR. FRAWLEY: He calls them proper name
10 drugs, properly priced, properly prepared -- may as well
11 get that plug in as well for the Lederle publicity and
12 that he says is \$18.00 a hundred.

13 MR. THOMPSON: Well let me express myself
14 this way: I don't know where the \$42.08 came from. It is
15 not a retail list price. It is not the price that a
16 physician or a pharmacist would pay to buy Achromycin
17 from a Lederle depot. It is a price that I find very
18 difficult to reconcile because I don't know where it came
19 from.

20 MR. FRAWLEY: But I would pay that in the
21 drug store. I mean I would pay \$43.13. He is saying I
22 would pay \$42.08.

23 MR. THOMPSON: I suggest, Mr. Frawley, that
24 you would also pay an appropriately higher price for the
25 product in the other column.

26 MR. FRAWLEY: Would it be something more
27 than \$18.00 a hundred?

28 MR. THOMPSON: I believe that Mr. Gilbert
29 is representing, and I have heard him say this -- apparently
30 Mr. Gilbert is willing to purchase Achromycin some place and



1 resell it at the prices you quote.

2 MR. FRAWLEY: Well now, let's understand
3 each other.

4 MR. THOMPSON: I don't believe you are
5 talking about list prices. Incidentally, Mr. Frawley,
6 there is a question of trade mark rights involved and I
7 would rather not be asked to discuss this since it may
8 come before the Courts.

9 MR. FRAWLEY: We wouldn't want you to. What
10 you are telling me now removes any dispute as to the
11 product you have made, I mean as to what these prices
12 mean but at least I can be satisfied that when he is
13 talking about Achromycin capsules 250 milligrams in the
14 one column, brand name column drugs, he is talking about
15 Tetracycline HCL capsules 250 milligrams in the other
16 column, he is talking about the same thing.

17 MR. THOMPSON: He is talking about prepara-
18 tion, two different preparations of apparently the same
19 drug.

20 MR. WAHN: Mr. Chairman, I would like to
21 ask one question here, if I may Mr. Frawley. I think
22 there is a misunderstanding. Mr. Thompson this \$18.00
23 price which has been quoted as being Mr. Gilbert's price,
24 and \$42.00 odd cents price that has been quoted as being
25 Achromycin prices, are these comparable prices?

26 MR. THOMPSON: No. In my opinion they are
27 not because -- I am expressing my own opinion -- because
28 I have, like you Mr. Frawley, to interpret what I read
29 in that catalogue. The price which Mr. Gilbert publishes
30 for his own product I presume is his selling price.



1 MR. WAHN: Selling price to whom?

2 MR. THOMPSON: I am sorry, thank you Mr.

3 Wahn. Selling price to a customer and physicians, for example.

4 THE CHAIRMAN: Or a drug store?

5 MR. THOMPSON: I believe he sells to drug
6 stores also.

7 MR. FRAWLEY: Perhaps you were not finished,
8 if you are finished -- you know a lot about Mr. Gilbert. I
9 do not know anything about him at all except his little book
10 in my hand. I see he has a place in Calgary, which is very
11 enterprising, I can buy -- that is the price to me. Now,
12 I may be entirely wrong but I am asking you these questions
13 with reference to this trade because I would think that you
14 would know practically anything that has to do with
15 Tetracycline. I would put it to you that I can go into
16 Mr. Gilbert's place in Calgary and for \$18.00 he would give
17 me 100 of these Tetracycline HCL capsules, 250 milligrams.

18 MR. THOMPSON: If he did that, Mr. Frawley,
19 it is my understanding that he would be violating the
20 Pharmacy Act in Alberta. If you had bought in Mr. Gilbert's
21 depot, you would have the equal privilege of going into
22 the Lederle depot and buying Achromycin at a much lower
23 price than the figure you see there.

24 MR. FRAWLEY: I would have to have a
25 prescription in my hand. I don't mean he would sell it to
26 me without a prescription. If I had a prescription, I am
27 putting it to you that I can get that for \$18.00.

28 MR. THOMPSON: The Lederle depot in Calgary
29 would not be permitted by law to accept your prescription
30 and fill it. It would have to be filled by a qualified



1 licensed pharmacy and that pharmacy would require a mark-up
2 in addition to his regular price in order to finance his
3 operation and what I am seeking to say to you Mr. Frawley
4 is that if you wish to talk about the price that Mr.
5 Gilbert publishes for his product that you cannot talk
6 about \$42.08 as being a comparable basis because it is not
7 true.

8 MR. FRAWLEY: Let me understand you: If
9 I went in with my prescription to some place where I could
10 buy Gilbert's products he wouldn't give me something that
11 had the name Lederle on it would he?

12 MR. THOMPSON: I would expect not. It would
13 be wrong.

14 MR. FRAWLEY: He would give me Tetracycline
15 HCL capsules. I would perhaps want to take them back to
16 my physician and make certain that it was what he said it
17 was. Even if I had gone in and bought Achromycin from
18 Lederle I would pay \$42.08 or \$43.18?

19 MR. THOMPSON: No Mr. Frawley. First of all
20 you would need a prescription.

21 MR. FRAWLEY: That is right. I would need
22 a prescription.

23 MR. THOMPSON: And you would have a bottle
24 of capsules that Mr. Gilbert handed to him. The pharmacist
25 would have bought those at the price Mr. Gilbert publishes
26 there, and he would have had to add a mark-up in order to
27 finance his operation. You wouldn't pay that price. You
28 would pay a higher price. I don't know how much higher
29 it would be. It would depend on the mark-up that he thought
30 it was necessary to add. Now, if you went into some store



1 with a prescription for Achromycin you would be starting
2 from a base, which is the price at which Lederle sells to
3 druggists which price does not appear in that catalogue.

4 MR. FRAWLEY: I wouldn't be starting at all.
5 I am just concerned to find out whether or not these
6 prices are available to a patient on a prescription.
7 That is what I am talking about.

8 MR. THOMPSON: I don't think either of those
9 prices would apply. Certainly wouldn't be the case with
10 the Achromycin but you know Mr. Frawley I would suggest
11 that you ask Mr. Gilbert about his prices.

12 MR. FRAWLEY: In view of what you are telling
13 me, I certainly will ask Mr. Gilbert. He sent me this and
14 when I acknowledge it I will ask him about this. For the
15 moment I will put it to you that the products are comparable
16 and I am putting it to you that on your column that is the
17 price quoted to the patient with the prescription. No
18 doubt about that.

19 MR. THOMPSON: Yes, there is a great deal
20 of doubt Mr. Frawley. I don't think that is true.

21 MR. FRAWLEY: You see if I were a patient
22 with a prescription I would have to pay \$43.18 in a pharmacy
23 in Calgary for Achromycin. Isn't that right?

24 MR. THOMPSON: Yes, if you need one hundred
25 capsules which would be most unusual.

26 MR. FRAWLEY: I know, but just for the sake
27 of comparison I am assuming now that I would like it so
28 well I am going to buy a hundred.

29 MR. THOMPSON: You don't look that sick
30 Mr. Frawley.



1 MR. FRAWLEY: In any event, that is the
2 price to the patient isn't it, \$43.13?

3 MR. THOMPSON: Yes.

4 MR. FRAWLEY: That is the list price?

5 MR. THOMPSON: Yes.

6 MR. FRAWLEY: It is your list price isn't
7 it? Lederle puts that list out?

8 MR. THOMPSON: Suggested list price, yes.

9 MR. FRAWLEY: I am not going to give you
10 any difficulty with some other Federal Statute. I am just
11 saying that it is a price that you suggest, \$43.13 and
12 you say, I think you call it a suggested list price and
13 the \$42.08 is so much in the same range that I am assuming
14 that that also is the patient's price?

15 MR. THOMPSON: Mr. Frawley, I will have to
16 explain to you in the plainest possible terms that your
17 assumption is wrong.

18 MR. FRAWLEY: My assumption is wrong?

19 MR. THOMPSON: Yes.

20 MR. FRAWLEY: Then this \$42.08, which is
21 so close to your \$43.13 that isn't a price to a patient?

22 MR. THOMPSON: I will express my opinion,
23 Mr. Frawley, as to how that price was computed. First of
24 all Mr. Gilbert has published that price several times
25 without changing it, even though the price of Achromycin
26 to the trade has declined twice. There has been no change
27 reflected in the price that Mr. Gilbert publishes in his
28 catalogue. Secondly Mr. Gilbert in order to offer
29 Achromycin would have to buy it like any other customer
30 at the regular trade price and he would have to mark up



1 that price to cover his cost.

2 MR. FRAWLEY: What are you talking about,
3 Achromycin capsules?

4 MR. THOMPSON: Yes.

5 MR. FRAWLEY: I didn't ask you about selling
6 Achromycin capsules at all.

7 MR. THOMPSON: Mr. Frawley, Achromycin is
8 available at a lower price than the price that Mr. Gilbert
9 publishes, to the same people and this catalogue is, as
10 I understand it, is circulated to physicians. Dr. Warminton
11 is on the mailing list of that catalogue.

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D/PB/hm 1

MR. FRAWLEY: Yes, it is.

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MR. THOMPSON: He is being offered Achromycin

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at \$42.08 a hundred in that catalogue.

4

MR. FRAWLEY: If I am the physician and

5

he is offering me Achromycin at \$42.08, I wouldn't pay

6

any attention to him at all.

7

MR. THOMPSON: You have apparently set

8

great store in reading the catalogue.

9

MR. FRAWLEY: I didn't regard it as price

10

to the physician.

11

MR. THOMPSON: There is a difference

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between our company and Mr. Gilbert on this issue. I

13

think you have misinterpreted the meaning.

14

MR. FRAWLEY: Let me understand, are you

15

saying what Mr. Gilbert is saying to the physician that

16

I will charge you \$42.08 for one hundred capsules of

17

Achromycin and you go to Lederle you get it for twenty-

18

eight something.

19

MR. THOMPSON: \$25.18.

20

MR. FRAWLEY: You are telling me that is

21

what Gilbert is advertising to the Canadian public.

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MR. THOMPSON: Yes.

23

MR. WAHN: Is that not the reason why you

24

feel it is a misleading publication.

25

MR. THOMPSON: I think Mr. Frawley has been

26

misled by the very thing that worries me. I think it is

27

morally wrong for Mr. Gilbert to state prices of Lederle

28

which differ from those at which they are actually sold.

29

MR. FRAWLEY: You can call me as a witness

30

when you go to court to establish it is misleading. I will



1 be one of the witnesses. What you are telling me is this
2 \$42.08 less than 40% he is offering.

3 MR. THOMPSON: He has not mentioned any
4 discount, Mr. Frawley. I can't assume there is a discount,
5 at those prices.

6 THE CHAIRMAN: You mentioned that price of
7 Achromycin had been reduced twice.

8 MR. THOMPSON: Yes.

9 THE CHAIRMAN: And Mr. Gilbert had continued
10 to quote the same price for Achromycin, the price he
11 shows of \$42.08. Was it ever the case that the price to
12 druggists or to doctors of Achromycin was \$42.08 per
13 hundred of this type?

14 MR. THOMPSON: Mr. Chairman, I am reluctant
15 to answer that from memory. I would have to go back and
16 check.

17 THE CHAIRMAN: It was quite a bit higher
18 selling price?

19 MR. THOMPSON: Yes, it was.

20 THE CHAIRMAN: I was wondering if he got
21 that when it was true and continued to use it.

22 MR. THOMPSON: The price in the issues of
23 Gilbert's Surgical News has remained unchanged through at
24 least two reductions, one at 15% and another at 10, so
25 that this figure does not reflect the decrease in price.

26 THE CHAIRMAN: I was wondering if originally
27 these prices had referred to the same sort of customer
28 sale?

29 MR. THOMPSON: I am sorry I don't have that
30 with me. I wish I had the pricing expert from the company



1 with me. I think you are probably right, but I can't be
2 certain.

3 MR. FRAWLEY: While we are here and it
4 might be well to have it in the same place. I don't
5 know whether I am going to have a Parke Davis man in
6 your witness chair or not. The price on page 26 where he
7 shows in the column, brand name drugs at professional
8 prices chloromycetin capsules -- I think
9 the capsules is also a Parke Davis trade name.

10 MR. THOMPSON: I don't know, Mr. Frawley.
11 I think you had better ask Parke Davis.

12 MR. FRAWLEY: 250 milligrams, \$42.08 a
13 hundred and across the page under the heading proper name
14 brand, proper name drugs properly priced, properly pre-
15 pared, chloramphenicol capsules, 250 milligrams, \$12.50
16 a hundred.

17 MR. THOMPSON: Are you asking me a question?

18 MR. FRAWLEY: You would prefer that I
19 didn't ask you anything about Parke Davis' prices.

20 MR. THOMPSON: I am in no position to talk
21 about a competitor's pricing process.

22 MR. FRAWLEY: I only want to ask one more,
23 on page 27 I find that he says the brand name drugs at
24 professional prices mobenol or orinase tablets 0.5 grams,
25 \$9.80 a hundred. He shows in the columns proper name
26 drugs, properly priced and properly prepared, tolbutamide,
27 \$3.75 a hundred.

28 MR. THOMPSON: My answer to that question
29 has to be the same.

30 MR. FRAWLEY: Yes, that is true. Do you



1 make dedomycin in Canada or buy from your U. S. parent?

2 MR. THOMPSON: We import the crude form
3 of demethylchlortetracycline and it is refined in
4 Canada and then put into the different dosage forms.

5 MR. FRAWLEY: Do you still pay \$340.05 a
6 kilogram to American Cyanamid.

7 MR. THOMPSON: We don't.

8 MR. FRAWLEY: You pay less than that?

9 MR. THOMPSON: We don't import it anymore
10 now.

11 MR. FRAWLEY: I misunderstood. I thought
12 you said you imported it in crude form and refined it.

13 MR. THOMPSON: This has been true in the
14 past.

15 MR. FRAWLEY: But now you don't import it
16 at all.

17 MR. THOMPSON: No, we don't.

18 MR. FRAWLEY: You manufacture it now?

19 MR. THOMPSON: That is correct. We don't
20 yet manufacture it, Mr. Frawley, to get the record straight.
21 We have started construction of a plant for this purpose
22 and importation of dedomycin crude has ceased.

23 MR. FRAWLEY: You have stock pile?

24 MR. THOMPSON: We have a small stock pile,
25 yes.

26 MR. FRAWLEY: How long do you think it will
27 be before you can manufacture at your expanded plant at
28 Welland for a better price than \$340.05 a kilogram that
29 you paid your American parent?

30 MR. THOMPSON: You have asked two questions.



1 I don't know yet, Mr. Frawley. We haven't got this plant
2 in operation. We don't know how successful we will be
3 in getting high yields. We don't know what it will cost
4 us to produce decbmycin in Canada.

5 MR. FRAWLEY: The \$340.00 price you paid,
6 I take it was satisfactory to you, was it?

7 MR. THOMPSON: It was satisfactory to us,
8 yes.

9 MR. FRAWLEY: It was made by your American parent
10 with a great deal of automation and a lot of outlets for
11 it.

12 MR. THOMPSON: Yes.

13 MR. FRAWLEY: I wonder why you didn't
14 continue to import it from the parent in the United States.

15 MR. THOMPSON: We came to believe that we
16 could economically manufacture it in Canada.

17 MR. FRAWLEY: That is what I asked, you
18 should not be manufacturing it in Canada unless you think
19 you can improve the \$340.00 price.

20 MR. THOMPSON: I disagree with you. I
21 would be content if we could meet that price.

22 MR. FRAWLEY: All right, but you wouldn't
23 want to build your plant if it was going to cost you
24 \$400.00 a kilogram.

25 MR. THOMPSON: Indeed I wouldn't.

26 MR. FRAWLEY: You expect \$340.00 a kilogram
27 or less.

28 MR. THOMPSON: Yes.

29 MR. FRAWLEY: What is the objective of
30 expanding that plant and going into the manufacture of the



1 basic drug that is called demethylchlortetracycline.

2 MR. THOMPSON: The objective is very simple,

3 Mr. Frawley. We will engage in manufacturing a preparation

4 which we call Aurofac which is the feed of Aureomycin

5 for animal use. It is a crude form suitable for animal

6 use. As I have told you we are seeking to reduce the cost

7 of that manufacturing process by adding capacity and by

8 making a multiple purpose plant out of the existing

9 facilities. In order to do so, to that end we are adding

2 10 facilities for further refinement of this crude material

11 so it will be suitable for human use. It is a multiple

12 operation. There will be Aureomycin produced for human

13 use. The Aureomycin will be converted to Achromycin for

14 human use and, in addition, we will use the same facilities,

15 to a large extent the same facilities to ferment and refine

16 decdmycin. We will have a combined operation. We believe

17 each element will add in lowering the cost for the other.

18 MR. FRAWLEY: You will allow that to be

19 reflected in your list price?

20 MR. THOMPSON: If there is a substantial

21 saving we will certainly hope to do that.

22 MR. FRAWLEY: Is anyone else striking out

23 like you are in expanding Canadian facilities to produce

24 finished dedomycin or whatever the other comparable product

25 is?

26 MR. THOMPSON: Not that we are aware of.

27 MR. FRAWLEY: Once more you are leading in

28 trade. I put it to you, I think quite fairly, are you

29 doing that so you can get a better list price or are you

30 doing it, nothing reprehensible about it, I suppose, to add



1 to your revenues so you can bring out more tranquilizers
2 or steroids.

3 MR. THOMPSON: There are three possibilities:

4 One is we may be able to reduce our manufacturing cost
5 of the veterinary preparations. The other possibility is
6 that we may be able to put ourselves in a more powerful
7 competitive position in this price competition I
8 described to you yesterday in the human broad spectrum
9 antibiotic field. The third possibility we would be
10 pretty proud to have a manufacturing facility in Canada
11 which could stand on its own feet economically.

12 MR. FRAWLEY: I can't get too enthusiastic
13 about a plant in Welland unless it is going to do some
14 good to the people of Alberta. That is why I am wondering
15 if you are going to do some good in the list price in
16 Alberta by expanding these facilities.

17 MR. THOMPSON: Mr. Frawley, the plant isn't
18 in Alberta.

19 MR. FRAWLEY: You say the plant is ---?

20 MR. THOMPSON: The plant isn't in Alberta.

21 MR. FRAWLEY: No.

22 MR. THOMPSON: It is perhaps unfortunate.

23 MR. FRAWLEY: It is regrettable.

24 MR. THOMPSON: It couldn't be in Alberta.

25 Perhaps the Province of Alberta could create a sufficiently
26 conducive climate so that industries of this sort would
27 go there. The transportation costs of antibiotics is not
28 great. There is no reason why this could not be brought
29 about. The greatest detriment to doing so would be the law
30 which I understand you are contemplating which would probably



1 make it impossible, certainly very difficult for our
2 company to engage in creative activities on new drugs such
3 as Temposil that we were talking about yesterday.

4 MR. FRAWLEY: I know what you are talking
5 about. I can promise you now I have no fears.

6 MR. THOMPSON: You might like to add it to
7 your note, it would cost \$27,000.00 to promote Temposil
8 in Alberta to 1,200 physicians effectively. This is,
9 of course, just an opinion.

10 MR. FRAWLEY: Tell me again, I didn't get
11 it.

12 MR. THOMPSON: We estimate it would take
13 an investment of about \$27,000.00 to bring this preparation
14 to the attention of the physicians in Alberta.

15 MR. FRAWLEY: Is this the anti-alcoholic?

16 MR. THOMPSON: Yes.

17 MR. FRAWLEY: I think it is a waste of time
18 to the people of Alberta.

19 THE CHAIRMAN: You don't mean one circular?
20 You mean a complete presentation?

21 MR. THOMPSON: I mean to tell the physicians
22 about it in an understandable form so they would see the
23 drug as our clinical advisers do.

24 THE CHAIRMAN: A full presentation, detail
25 men?

26 MR. THOMPSON: Complete promotion.

27 MR. FRAWLEY: It wouldn't take \$27,000.00
28 if you went to Belmont. We have an institution for alcoholics.
29 Have you ever tried talking to the people at Belmont?

30 MR. THOMPSON: Indeed we have, Mr. Frawley.



1 MR. FRAWLEY: I supposed you had.

2 MR. THOMPSON: Oh, yes.

3 MR. FRAWLEY: I don't think Cyanamid, either
4 Canadian or American misses very much in the marketing
5 of drugs. If you interested Belmont you wouldn't have to
6 interest the physicians. It is a specialized job, isn't
7 it, alcoholism?

8 MR. THOMPSON: We don't think so. We are
9 advised that a drug of this character, such as Temposil,
10 can be used in general practice, and hope to avoid the
11 need for institutional treatment.

12 MR. FRAWLEY: There was a statement on page
13 170 of the Directors submission I wanted to ask you about.
14 It rather struck me. It is still about the refinement of
15 this demethylchlortetracycline. It is at page 170,
16 paragraph 289 :

17 "Demethylchlortetracycline is sold in Canada
18 by Cyanamid under the trade name Declomycin.
19 It was first marketed in October 1959. The
20 drug is purchased in the crude form from
21 American Cyanamid Company at \$340.05 per
22 kg. and refined in Canada. Total cost of
23 the refined drug was reported by Cyanamid
24 as \$606.47 per kg."

25 What happened to make that increase of 100 per cent by
26 merely refining it? There must be some explanation of that.

27 MR. THOMPSON: Yes there is, Mr. Frawley.
28 There is invariably a loss in refinement. You don't get
29 it all.

30 MR. FRAWLEY: A physical loss?



1 MR. THOMPSON: Physical loss of the active
2 ingredients and the cost of the finished product depends
3 to some extent on the yield, which varies.

4 MR. FRAWLEY: If you have imported from the
5 American, if you imported the finished product would you
6 have to pay \$606.47?

7 MR. THOMPSON: The finished product would
8 be subject to duty at the border, which would be a new
9 factor because we have been privileged to import the
10 crude material duty free, due to the further manufacture
11 which is carried on in Canada, so there would be a new
12 charge introduced. I don't know what we would pay.

13 MR. FRAWLEY: Your parent at that time was
14 selling you the crude form at \$340.00 a kilogram. Do you
15 mean to say that they couldn't have done better than
16 \$606.47 if you asked them to sell you the refined product?

17 MR. THOMPSON: Mr. Frawley, I don't know
18 because I didn't ask them. I do know our company would
19 have to pay a duty to the Government of Canada which is
20 not necessary in the situation where you import the crude
21 material.

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/dpw

1 MR. FRAWLEY: Mr. Thompson, at page 14 you
2 quoted with apparent approval something that the President
3 of Merck said appearing before the Kefauver Committee,
4 and the gist of what the gentleman said was that there is
5 a better cost picture when the manufacturing takes place
6 where basic costs are lower. That is borne out by the
7 Kefauver Report.

8 The report of the Kefauver Committee dated
9 June 27 1961, which I take it you have seen - and I call
10 your attention before I ask my question to the fact that
11 you say on page 6 that you discontinued importing Mepro-
12 bamate. Is that the right way to say it?

13 MR. THOMPSON: I guess that is a matter of
14 opinion, Mr. Frawley.

15 MR. FRAWLEY: You discontinued importing
16 that product from American Cyanamid when Fine Chemicals
17 began making it in Canada. I take it that was because it
18 was more economical or profitable to obtain your supply
19 from Fine Chemicals, rather than importing it from American
20 Cyanamid?

21 MR. THOMPSON: Yes.

22 MR. FRAWLEY: I might gather you didn't pay
23 Fine Chemicals more than you were paying American Cyanamid.

24 MR. THOMPSON: No, we would not like to do
25 that.

26 MR. FRAWLEY: You have plants in many
27 countries, I suppose?

28 MR. THOMPSON: Yes.

29 MR. FRAWLEY: Just for the record would you
30 tell us where, as you recall, you have plants?



1 MR. THOMPSON: My memory is not good enough
2 to complete this answer, but maybe Mr. Bowman can help me
3 with that. There are some 50 foreign plants I believe.

4 MR. BOWMAN: 50 altogether.

5 MR. THOMPSON: 50 altogether and six of
6 those are in Canada.

7 MR. FRAWLEY: How many in Canada?

8 MR. THOMPSON: Six.

9 MR. FRAWLEY: Manufacturing plants?

10 MR. THOMPSON: Yes.

11 MR. FRAWLEY: For pharmaceuticals?

12 MR. THOMPSON: No.

13 MR. FRAWLEY: How many plants for pharma-
14 ceuticals?

15 MR. THOMPSON: We have one plant for pharma-
16 ceuticals in Canada.

17 MR. FRAWLEY: One in Canada?

18 MR. THOMPSON: And our second plant is
19 partially engaged - the Welland plant is in the basic
20 antibiotic manufacturing business.

21 MR. FRAWLEY: And you have plants in some
22 of those foreign countries where conditions apply that
23 you refer to on page 14?

24 MR. THOMPSON: Yes.

25 MR. FRAWLEY: Where you would obtain the
26 benefit of lower costs?

27 MR. THOMPSON: Oh yes.

28 MR. FRAWLEY: Well now, I put it to you,
29 would the Canadian consumer be benefited if you marketed
30 in Canada products which you made outside Canada at less



1 cost?

2 MR. THOMPSON: No.

3 MR. FRAWLEY: Why?

4 MR. THOMPSON: Import duty is one factor,
5 and it is not the only factor. Mr. Frawley, do you
6 seriously think that we would maintain a manufacturing
7 operation in Canada which is economically unsound?

8 MR. FRAWLEY: I simply put it to you, could
9 you not? I don't know. With all the discussion about the
10 fact that in foreign countries you can manufacture at
11 lower costs, I suggest that you might take advantage of
12 those more favourable conditions and supply your Canadian
13 market from those plants.

14 MR. THOMPSON: There is much more involved
15 in making drugs available to the people of Canada than
16 just the manufacturing cost. I mention to you the esti-
17 mated cost of promoting Temposil in Alberta. If I could
18 import detail men from India at a couple of rupees a day
19 salary, have them travel at the cost of travel in India
20 and live under the conditions that our detail men in India
21 enjoy, I could cut that very substantially, but this is
22 not possible in Canada. We are Canadians. We have to
23 live with the standard of living, with the costs that go
24 with it as they are in Canada, and we cannot import the
25 promotional element from another country, and I wish to
26 emphasize that if we could better import products and
27 sell them here, we would do so.

28 MR. FRAWLEY: Well now, what you are saying
29 is that you could have a better landed cost if you made
30 Achromycin in England, but the landed cost in Canada would



1 be only the starting point, as you would have so much
2 extra expense that you would not have any advantage at
3 all, you might just as well make it here and use the
4 Canadian manufacturing cost as a starting point.

5 MR. THOMPSON: I would, sir. I would import
6 any product if I thought I could gain in terms of cost.
7 Our company is not averse to improving its margin of
8 profit if it can do so.

9 THE CHAIRMAN: Mr. Thompson, just to get this
10 clear, does your evidence of this last few minutes mean
11 that while it may cost less to actually manufacture a
12 drug in some foreign country than it does in Canada, by
13 the time you have paid duty and transportation, the laid-
14 down cost at your plant in Canada, delivered here, would
15 not be less?

16 MR. THOMPSON: That is correct.

17 THE CHAIRMAN: - than your manufacturing
18 cost here?

19 MR. THOMPSON: That is correct. We have to
20 satisfy the Department of National Health and Welfare on
21 each imported lot, and the labelling has to comply, and
22 normally re-labelling is necessary. It is wasteful and
23 an uneconomic process, and by the time we get the product
24 on the shelf in Canada, it would not be more economical.
25 That was the case with this article otherwise we would
26 not have built a plant in Montreal.

27 MR. FRAWLEY: Of course the witness has
28 added something to your question, Mr. Chairman, and just
29 to let me follow it up, and I certainly mean that not
30 offensively.



1 The Chairman put it to you if you had taken
2 the drug manufactured at less cost in the foreign country
3 and paid duty and sales tax and landed it at seaport in
4 Canada, would the difference in cost disappear? I didn't
5 take you to mean that, and I wonder whether you do mean
6 that - just the landed cost after you have paid the duty
7 and the sales tax.

8 MR. THOMPSON: Yes indeed. The cost of
9 putting Aureomycin capsules on the shelf in Canada for
10 sale from our British facilities would be greater than
11 the cost of manufacturing them in Montreal. Otherwise
12 we would shut down the Montreal plant and pay the deprecia-
13 tion on it.

14 MR. FRAWLEY: I simply want the Chairman to
15 understand this is quite a different thing because now you
16 are adding the promotional cost in Canada to get it on the
2 17 druggist's shelf or in the doctor's office.

18 MR. THOMPSON: No, on the shelf, I mean on
19 our shelf, Mr. Frawley, on our warehouse shelf.

20 MR. FRAWLEY: I was giving you the seaport
21 price.

22 MR. THOMPSON: There is a difference between
23 the seaport price, let us say in Halifax, and the price
24 by the time that preparation has cleared customs, passed
25 inspection by the Department of National Health and Welfare
26 to ensure that it has the proper "PR" symbol which is
27 required only in Canada, and has been transmitted to the
28 Lederle depot shelf. We must comply with our Food and
29 Drug Act before our product is available for sale.

30 MR. FRAWLEY: I am very glad to be corrected.



1 So just simply the customs duty, and the sales tax, and
2 the cost of getting it through the Department of National
3 Health and Welfare in Ottawa - those three items would
4 make the difference between the low manufacturing cost
5 in the foreign country and the - I won't say "high", but
6 the manufacturing cost in Canada.

7 MR. THOMPSON: Yes.

8 MR. FRAWLEY: Just that. So that the magic,
9 the advantage of importing European drugs is gone then.

10 MR. THOMPSON: It does not exist for our
11 company.

12 MR. FRAWLEY: All right, for your company.
13 After all you are just Lederle, because I am going to
14 suggest to you that there is such a terrific spread - I
15 am not saying "profit", just "spread" between the cost of
16 Largactil that is imported and the cost to the public of
17 Largactil, I am suggesting, could not be accounted for in
18 the cost of merely customs duty and the sales tax. Perhaps
19 again because it is not your product you would not care to
20 comment on it.

21 MR. THOMPSON: I have to appeal to the
22 Chairman, I cannot speak for a competitor's price. I
23 would be glad to talk about Lederle antibiotics in foreign
24 countries, if you care to do so. I have done so in my
25 brief.

26 MR. FRAWLEY: No, I take it from you now
27 that the advantage of the low-cost countries - and I don't
28 why these people were telling the Kefauver Committee and
29 why you were making quite a bit of it on page 14, because
30 you say now that all disappeared by the simple business of



1 paying the duty, the sales tax, and the expense of putting
2 it through the Federal regulations in Ottawa.

3 MR. THOMPSON: Yes, Mr. Frawley, and let us
4 be clear we are talking about the shelf cost.

5 MR. FRAWLEY: Shelf cost? About what?

6 MR. THOMPSON: Shelf cost.

7 THE CHAIRMAN: You mean you are talking
8 about the total cost up to the point where the product is
9 on your shelf?

10 MR. THOMPSON: Yes, Mr. Chairman.

11 THE CHAIRMAN: Whether manufactured by you
12 in Montreal or manufactured in some foreign country and
13 imported.

14 MR. THOMPSON: Correct.

15 THE CHAIRMAN: From there on you have
16 Canadian costs?

17 MR. THOMPSON: Yes indeed, that is correct.

18 MR. FRAWLEY: Well then, you will have to
19 bear with me. I must ask you why you think there was any
20 value at all because it does not apply in the case of
21 your product. In quoting on page 14 of the presentation,
22 you quote what the President of Merck said, and I shall
23 read it:

24 "It is evident that where we have the bene-
25 fit of those lower costs, we can sell our
26 finished pharmaceutical products at a lower
27 price than would be possible in the United
28 States".

29 Are you referring to that because you want
30 to talk about something Mr. John K. Connor said?



1 MR. THOMPSON: Are you referring to Mr.
2 John T. Connor?

3 MR. FRAWLEY: Yes. The statement you quote
4 on page 14, it was a statement made by Mr. John T. Connor
5 and frankly, before you answer, let me tell you what is
6 in my mind. I don't see any point in playing down and
7 explaining away and putting in their true light these
8 lower costs in the foreign countries because they don't
9 mean anything as soon as you pay the Canadian customs,
10 the duty, the sales tax and the Department of National
11 Revenue costs.

12 MR. HALL: If I might interject one word
13 that might assist my learned friend, if you will refer to
14 page 13 of our brief, the second paragraph mentions the
15 reason why these quotations from the Kefauver Committee
16 have been reproduced. It is an attempt to clarify the
17 Statement of the Director, Chapter XVI which mentions
18 these, but there was no attempt to explain the reason why.

19 MR. FRAWLEY: My friend calls my attention
20 to page 13 which is a general statement in which the
21 witness generally questions the impression that people
22 obtain when we talk about cheaper costs and prices in the
23 European market, but then he proceeds to quote and to put
24 his finger on the benefit that comes from these costs in
25 the foreign countries, and he makes it clear to the
26 Commission that in the case of Lederle's products there
27 is no use talking about it because as soon as you pay the
28 duty which you must, and the sales tax which you must,
29 and the cost of putting it through the different depart-
30 ments at Ottawa, which you must, that the shelf price is



1 equalized.

2 MR. THOMPSON: Yes, Mr. Frawley. We are
3 talking about shelf costs. We are talking about shelf
4 costs and I suggest that you are quoting my reference to
5 Mr. Connor in a different light and I would like to read
6 to you one sentence on page 13. It is the first sentence
7 of the second paragraph:

8 "We feel it necessary to point out that
9 too frequently, when foreign or European
10 prices are compared with Canadian and
11 U.S. prices, the impression is given that
12 the North American drug industry subsidizes
13 the European market, that it manufactures
14 a product here and markets it abroad at
15 greatly reduced cost".

16 We are not talking about shelf cost, we
17 are talking about prices.

18 "---are compared with Canadian and U.S.
19 prices, the impression is given that the
20 North American drug industry subsidizes
21 the European market, that it manufactures
22 a product here and markets it abroad at
23 greatly reduced cost".

24 What I want to talk about is the marketing
25 cost, which is the next element after shelf cost and if
26 you will refer to page 14 of the brief which you just
27 quoted, the reference to Mr. Connor is, Mr. Connor is
28 talking about total costs, not just shelf costs in
29 foreign countries, and he says:

30 "--- a pharmaceutical detail man in England



1 is paid --- about \$210 in U.S. money
2 compared with \$600 or more a month in the
3 United States".

4 This then refers to the element of marketing
5 cost which must next be considered in establishing price,
6 and as I have said, Mr. Frawley, I would like to make
7 sure it is crystal clear we are confronted by Canadian
8 marketing costs, not British or European marketing costs.

9 MR. FRAWLEY: Well now, we have spent so
10 much time about comparing the cost of making goods abroad
11 and making them in Canada that I think I will read some-
12 thing from the Kefauver Report, from the report of what
13 is commonly called the Kefauver Committee which was
14 issued on June 27, reading from page 43:

15 "Lower wage rates were the most frequently
16 cited explanation for the lower prices
17 abroad. For example, when Mr. John T.
18 Connor of Merck was asked to explain the
19 extraordinary difference between the
20 price of Merck's Prednisone to the English
21 druggist (\$7.53 per 100 tablets) and the
22 price to the U.S. druggist (\$17.90) he
23 stated ---"



F/ENT/hm 1

"We are all familiar with the fact that foreign material labor, and other costs of doing business are frequently below our own...

It is evident that where we have the benefit of these lower costs, we can sell our finished pharmaceutical products at a lower price than would be possible in the United States.

And then they quote something from John E. McKeen of Chas. Pfizer & Co.:

"Any U. S. manufacturer who sells drugs or other products abroad will tell you that the lower wage rates in foreign countries result in much lower costs in every phase of business operation, in production, in selling, distribution, administration, and so forth.

And this report goes on:

"This explanation of course would apply not at all where the manufacturing operations are conducted entirely in the United States, and only to a slight extent where the bulk powder is made here and the tableting and bottling done abroad. But even where this is not the case, production costs are so low that differences therein could hardly be sufficient to explain price differentials of the magnitude observed. Where a product such as prednisolone sells in England for 7.5 cents per tablet and in the United States for 17.9 cents, it is difficult to see how differences in wage costs (which constitute



1 only a small proportion of total manufac-
2 turing costs) could possibly explain a
3 difference in price which is more than six
4 times the total cost of producing, tableting,
5 bottling, and packaging the product in the
6 United States."

7 MR. THOMPSON: What is your question, Mr.
8 Frawley?

9 MR. FRAWLEY: It is a question, and it is
10 a question for the Commission.

11 MR. THOMPSON: What is your question? You
12 are asking me a question. I am sorry, I don't understand.

13 MR. FRAWLEY: I am simply asking in the
14 light of what the Kefauver Report says, then why do you
15 take such comfort from the fact that the cost -- I say
16 "comfort" -- the fact that you quoted it in your brief,
17 the fact that European costs are lower? My question is
18 if European costs are lower, then you should bring these
19 products into Canada and sell them here. But then, you
20 counter that by indicating they don't mean anything in the
21 hands of your company for by the time you get it on the
22 shelf all that cost difference has been washed out.

23 MR. THOMPSON: That is right.

24 MR. FRAWLEY: Then just leave it there.

25 MR. THOMPSON: Now, you have repeatedly
26 mentioned, Mr. Frawley, the European and Canadian or
27 European and American price comparison of other companies.
28 I would like to say to you, Mr. Frawley, that I do not
29 apologize for the differentials that our company faces in
30 the comparing of, let us say, Achromycin, with prices in



1 Colombia, Venezuela, Mexico, Canada and the United States,
2 and I would be glad to talk further about this if you wish
3 to do so, but I cannot talk about a competitor's prices.

4 THE CHAIRMAN: I think we had better have
5 a break.

6 MR. THOMPSON: Thank you, Mr. Chairman.

7
8 ---Short recess.

9
10 MR. FRAWLEY: Mr. Thompson, the green book
11 at page 169 states that Cyanamid reported it manufactured
12 tetracycline in Canada at a cost of \$644.15 per kilogram.
13 Does that still obtain at the present time?

14 MR. THOMPSON: It is in that range, Mr.
15 Frawley, but I do not have the latest figure. It varies
16 from lot to lot according to the yield.

17 MR. FRAWLEY: Now then, you have said in
18 your statement yesterday that it is listed at \$43.13 a
19 hundred?

20 MR. THOMPSON: Yes.

21 MR. FRAWLEY: A hundred tablets. Now, would
22 it not be a simple operation for you to take the \$43.13
23 or the other figure of \$7.11 for packages of 16, and break
24 that down? When I say "break it down", let me give you an
25 idea of what I mean. I would suggest it could be broken
26 down into the cost, into the formulation expense, into the
27 sampling expense, into the expense of the detail men, the
28 advertising literature expense, and then such other matters
29 as the cost of the low quotations to Government Departments,
30 if that could be regarded as a cost, and then you would see,



1 or you probably already have seen, but the Commission
2 could see and the public could see just who or what
3 factor is offending, if any factor is offending, or that
4 there are no offending factors.

5 I put it to you, Mr. Thompson, you should
6 consider doing that and filing it with the Commission and
7 making it part of the record. I do say so, and I say so
8 maybe not facetiously, but you might answer some of the
9 anguished public outcry that you refer to on page 1 of
10 your statement.

11 What do you think of that Mr. Thompson?

12 MR. THOMPSON: I am a little surprised, Mr.
13 Frawley, that you would suggest that I dismantle my price
14 structure and lay it bare to my competitors. And I may
15 answer further that our company has already furnished
16 considerable data in this regard to the Director in
17 confidence.

18 MR. FRAWLEY: Well now, what would be wrong
19 to simply show where the big expense is? I am certainly
20 anxious to know and the people I represent are anxious to
21 know. If there is too much promotional expense, it could
22 be looked at. It could be looked at.

23 MR. THOMPSON: There is a good deal of
24 information about that in the Green Book, Mr. Frawley. I
25 assume you have read that.

26 MR. FRAWLEY: You see there are some figures,
27 and I don't know what you think about them, whether you
28 would agree with them or not, but there are some American
29 figures that indicate that 38% -- and I gave my copy of
30 Kiplinger to the reporter -- that the starting cost, the



1 basic cost of the product is 38%, that the cost of getting
2 it to the market is 38%, the taxes are 12%, and 12% is
3 left for the manufacturer.

4 Now, that is American, and when I get the
5 book back I want to quote it to you in fairness to you
6 rather than just my sketchy outline of it. It is just a
7 few lines, but whatever they are, will it be important to
8 the public of Canada if they could know what percentage is
9 made up of this promotional cost which you say is not a
10 waste at all. You say it is a very valid and necessary
11 expense; nothing to be ashamed of. Wouldn't it be a
12 proper thing ---

13 MR. THOMPSON: Let me answer that in two
14 parts. First of all, if I thought there was any waste,
15 any element of waste in the economics of my company, I
16 wouldn't be able to sleep at night until I got that
17 corrected.

18 Number two, I suggest to you, Mr. Frawley,
19 that the figures that would be of greatest interest to the
20 public, as you feel the public is interested in this subject
21 and I am delighted that they are, would be figures that
22 represent a broad base of the industry.

23 It would be unfair and I think irrelevant to
24 consider a company which is heavily engaged in one particular
25 class of medication, for example, which might be a typical
26 company, but I think it is very relevant to consider the
27 figures that are averages or which are the result of con-
28 sidering a broad base of chemical, pharmaceutical manufacturers,
29 and the the Green Book contains such figures. They do not
30 serve your purpose, Mr. Frawley?



1 MR. FRAWLEY: No, it would not serve my
2 purpose at all. Frankly I thought when I saw that you
3 reported your company manufactured Tetracycline in Canada
4 at a cost of \$644.15 per kilogram, and you say it is still
5 in that range, that it would be a perfectly understandable
6 thing for you to sit down and break down the make-up between
7 \$644.15 and the \$43.13 that you sell it at to the public.

8 MR. THOMPSON: That figure that you have
9 quoted several times, Mr. Frawley was one which we furnished
10 on the understanding that it was to be a confidential
11 figure.

12 MR. FRAWLEY: The figure from page 169?

13 MR. THOMPSON: Yes. The Director chose to
14 publish it in the Green Book. I do not regret that he has
15 done so, but I do not feel it is proper for you to ask
16 me to reveal to my competitors further elements of my cost
17 structure.

18 MR. FRAWLEY: There is no use getting into
19 a philosophical discussion with you, but, Mr. Thompson,
20 let me say as far as my people are concerned I haven't
21 heard any anguished outcry -- that is your language so I
22 will use it -- there won't be any abatement of the anguished
23 outcry if you don't put this on the table. People will
24 still say they are taking 50% into their pockets; their
25 research doesn't really amount to anything but a few
26 pennies. You can settle all that by simply saying "Gentlemen,
27 this is what it is like; this is what it cost us to
28 formulate it, tablet it, capsule it; this is what it cost
29 to send out detail men". You have done it. Management
30 would want it from you, and you have probably furnished it



1 every six months to the management.

2 MR. THOMPSON: Let me answer your question
3 veryspecifically. You raised two particular points and
4 I would like to answer those. Number one, in connection
5 with research. The research cost element in our pricing
6 structure is about 9.6% in Canada, and I would like to say
7 that I would again not be able to sleep at nights if I
8 thought that money were being wasted.

9 MR. FRAWLEY: That is all very well, but
10 that is just a little figure of speech, Mr. Thompson, for
11 you to say you wouldn't sleep at night. Think of the
12 people who can't sleep at night because they have to pay
13 large sums of money for drugs when their doctor puts them
14 on a drug therapy programme for six months, and they have
15 to shell out money week after week after week at \$13.40
16 a hundred. Think about the sleep those people lose, and
17 then accept my invitation which would answer it all by
18 spreading it out on one sheet of foolscap.

19 MR. THOMPSON: Wouldn't you rather pay
20 \$15.00 to \$20.00 for an antibiotic to cure yourself of
21 pneumonia rather than to pay what it used to cost which
22 was more like \$1,000.00, Mr. Frawley?

23 MR. FRAWLEY: Of course now that you have
24 asked that question, it is not fair to ask what I would
25 do. Certainly I would do it, but I am not speaking here
26 for myself. I am talking about all the great run of the
27 marginal income men, the poor man who is put on therapy
28 that is expensive, so expensive that the Government of
29 Alberta, as you know -- there was another part of our
30 statement; it didn't seem to have startled you as much as



1 the one about our suggestion about generic versus brand --
2 that you know in Alberta we have two programmes, one a
3 rheumatic fever prophylaxis programme which involves
4 Penicillin G and a diabetic tolbutamide therapy programme
5 which involves the drug Tolbutamide.

6 We are doing that because these people can't
7 afford to pay expensive prices for those drugs. You know
8 of the statement attached to the exhibit with the statement
9 we filed in Edmonton. You know the Alberta government
10 buys this Penicillin G for \$2.95 a hundred, but if the man
11 wasn't able to get it free from us, he would have to pay
12 \$19.25 a hundred.

13 MR. THOMPSON: Mr. Frawley, I resent you
14 using me as a foil for making speeches about my competitor's
15 pricing practices.

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/dpw

1 MR. FRAWLEY: I know, but it is very diffi-
2 cult. I really should apologize for that. I have no
3 alternative for that. If I thought that British Drug
4 Houses was going to be where Mr. Thompson is standing and
5 if I thought that Hoechst Pharmacy - if that is the way
6 they say it - the people who sell us the tolbutamide were
7 going to be there, I certainly wouldn't be throwing
8 these questions at you. I know my friend rose to object.

9 THE CHAIRMAN: The difficulty of course,
10 is Mr. Thompson is in no position to answer the question.
11 Therefore, I don't think you should pursue it.

12 MR. FRAWLEY: Except that he invites these
13 kind of questions Mr. Chairman because he puts it to me
14 what I will do if my child was suffering from pneumonia.
15 Of course I would go out in the middle of the night and
16 pay \$25 a tablet to save that child's life but that isn't
17 really what this Commission is concerned with.

18 THE CHAIRMAN: Mr. Thompson is certainly
19 not in the position, as he said several times, to answer
20 questions about his competitors.

21 MR. FRAWLEY: Oh yes, I know. Quite so.
22 I am only explaining why I got into these questions.

23 THE CHAIRMAN: I think you should avoid
24 those questions. He is not in a position to answer them.
25 We are putting something on the record to which we cannot
26 get an answer we can use.

27 MR. WAHN: I rose a few minutes ago to say
28 that I think Mr. Frawley, my learned friend Mr. Frawley,
29 has brought out a great deal of useful information in
30 cross-examination this morning, but it does seem to me to



1 some extent he is getting beyond the scope of this parti-
2 cular inquiry, particularly with reference to the prices
3 of the industry, high cost of drugs in the industry
4 generally. I think perhaps the prices should relate to
5 the witness' company, the company he represents.

6 THE CHAIRMAN: The questioning has been
7 going rather farther afield than the Terms of Reference
8 under which the Commission is acting. As I explained
9 early in the hearings, when they first began last Spring,
10 we are not concerned in this inquiry with prices as such.
11 We are concerned in knowing whether prices are adversely
12 affecting the public in monopolistic situations or any
13 arrangements that amount to the restriction of trade, and
14 if prices are adversely affecting the public, we are very
15 much concerned with it.

16 MR. FRAWLEY: Now of course Mr. Chairman
17 I am questioning - I don't like to use the word cross-
18 examining - I am questioning this very knowledgeable Mr.
19 Thompson very extensively and he is to be commended for
20 coming here at all, but I am questioning him on some of
21 the things he said, and this is one of the things he said:
22 "Yet within only the last two or three years there has
23 been an anguished public outcry over North America that
24 the cost of medication is enormously high. The cry has
25 been taken up by politicians in both Canada and the United
26 States and characterized as an expression of popular
27 discontent". In my questioning of Mr. Thompson I am
28 indicating a way in which he can rid himself of that and
29 that is why I put it to Mr. Thompson, and his counsel
30 arose - if they are not going to do it; if we are not



1 going to indicate the breakdown of the \$43.13 for 100
2 tablets of Achromycin or Declomycin then I will stop my
3 questions. That is all sir.

4 THE CHAIRMAN: What Mr. Thompson said in
5 that regard was that he did not think he should be asked
6 to break this down for the benefit of his competitors.

7 MR. WAHN: Mr. Chairman, Mr. Thompson also
8 said that the Commission had been supplied ---

9 THE CHAIRMAN: A great deal of information
10 had been supplied.

11 MR. WAHN: To the Commission and I suggest
12 that if they really require it for the purpose of Mr.
13 Frawley, that he break it down on an industry basis rather
14 than on the cost figures of the individual companies.

15 MR. FRAWLEY: But it is much more serious
16 than that.

17 THE CHAIRMAN: Are you suggesting that Mr.
18 Thompson and other companies might let the Commission have
19 this sort of breakdown in confidence and the Commission
20 could then work on an industry-wide summary?

21 MR. FRAWLEY: Of course, I thought from what
22 Mr. Thompson said that the Commission already had that.

23 THE CHAIRMAN: They have a good deal of
24 information on it.

25 MR. FRAWLEY: I thought that Mr. Thompson
26 was going to - I am glad he did not - I thought he was
27 going to take the position that he couldn't do that
28 because there would be so many arbitraries to be allocated
29 and he couldn't do that. I am very glad to see he doesn't
30 object to my question on that ground at all. Simply says



1 I don't want to do that because it would give comfort to
2 my competitors. How often have we heard that?

3 THE CHAIRMAN: No manufacturer
4 wants to expose the breakdown of his various costs so
5 that his competitors can see where they are ahead of him
6 and where they are behind him and gain some better advan-
7 tage.

8 MR. THOMPSON: Our company has worked at
9 great length to increase the efficiency, the economic
10 efficiency of the business we have. We have had some
11 small success and we have no desire to share this with
12 our competitors. I am sure you would understand that
13 Mr. Frawley.

14 MR. FRAWLEY: I am sure that your company
15 is a reputable company and nothing is further from my
16 plans than to cast any aspersion on the company or its
17 personnel but they complain about the anguished outcry.
18 They complain about the cry being taken up by politicians
19 and this is the way to educate the public; to remove the
20 anguished outcry. This is the way to satisfy the politi-
21 cians. I am not here representing the politicians, but I
22 am here representing the people that have made some
23 anguished outcry.

24 Now, your answer then is you do not choose
25 to put any such document in the form I suggested, which is
26 a mock-up with decimal points indicating where this money
27 is being spent.

28 MR. THOMPSON: I would be happy to furnish
29 it to the Commission in confidence Mr. Frawley. We have
30 no desire to hold secrets from the Commission.



1 MR. FRAWLEY: You would not go this far: would
2 you work it out, and then put on the record the percen-
3 tage points that 7.11 or 43.13, that accounts for the,
4 what I have called the sampling expenses, detail men
5 expenses, advertising literature - if you would separate
6 that out and indicate and say that of the 7.11 that is
7 11 cents or \$7. I don't know which.

8 MR. THOMPSON: Possibly something in between.

9 MR. FRAWLEY: Would that be giving aid
10 and comfort to the enemy if you did that?

11 MR. THOMPSON: It most assuredly would
12 Mr. Frawley. I have attempted to say that to you before.
13 I will be glad to repeat it.

14 MR. FRAWLEY: Now there have been doctors
15 here, reputable doctors before this Commission who indi-
16 cated - and there is an account of it and if anybody
17 wants to spend the time reading the Kefauver Report -
18 that this is an enormous waste.

19 MR. THOMPSON: I suggest those comments
20 are made by gentlemen who have never been in the pharma-
21 ceutical business. There are many experts all of a sudden
22 who have never had experience in this business.

23 MR. FRAWLEY: How about the doctor that
24 takes 100% of your receipts from Lederle and puts 90% in
25 his wastebasket? If there are those kind of people you
26 would have to admit it was wasted effort.

27 MR. THOMPSON: I most certainly would not
28 admit that. What do you suggest happens to medical
29 journals after they have been read? What I am interested
30 in is what happens to advertising material between the



1 time it reaches the physician's office and the time it
2 goes in the wastebasket. It must inevitably end up some
3 place but I am interested in what happens to it when it is
4 in that physician's office and you may be interested in a
5 little evidence in that regard.

6 This is just one example of a direct mail
7 campaign, single mailing in fact and this is reported in the
8 Medical Mailer, which is a newsletter from Canadian
9 Mailings Limited dated June 1961 and I would like to quote:

10 "A major Montreal Pharmaceutical house..."
11 and this incidentally was not our company -

12 "...recently mailed to 10,959 general
13 practitioners and pediatricians. The
14 mailing consisted of a postage-saver,
15 postal permit envelope containing a
16 simple one-page letter accompanied by
17 an unstamped return card (request for a
18 sample of a pediatric product). The
19 return card required the doctor to write
20 out his name and address, sign and put
21 his own postage stamp on it. To date,
22 this mailing to 10,959 doctors has
23 brought 2,943 completed, stamped returns".

24 THE CHAIRMAN: What was the date that was
25 sent out?

26 MR. THOMPSON: June. This bulletin Mr.
27 Chairman is dated June 1961. It says recently in regard
28 to the timing of the mailing.

29 MR. FRAWLEY: What were they advertising?

30 MR. THOMPSON: I will have to read what they



1 say. It was a request for a sample of a pediatric product.
2 We don't know the nature of the product.

3 MR. FRAWLEY: They don't report the ---

4 MR. THOMPSON: But I have personally signed
5 letters to physicians in Canada and I will give you -
6 quote you an example, similar example of a letter sugges-
7 ting the use of a preparation containing a narcotic and
8 inviting the physician to return a reply card to obtain a
9 small sample, very modest sample of this narcotic prepara-
10 tion and the sample would then be sent to him.

11 As you probably are aware Mr. Frawley
12 before we are permitted to despatch a sample containing
13 a narcotic under Federal law we are required to have on
14 file a signature in ink made by the physician personally
15 indicating his desire to have this shipment made.

16 The mailing that I am thinking of brought
17 back a return of more than 27% of these cards and there-
18 fore we know that this percentage of the mailing reached
19 the personal attention of the physician who signed it and
20 whose signature has to be verified so I suggest to you
21 Mr. Frawley this is useful, as many physicians believe
22 but the physicians who have testified before this Commis-
23 sion apparently do not.

24 MR. FRAWLEY: I am interested in - you are
25 in a position to give, in the case of your company, infor-
26 mation, and this only supports my humble request and
27 petition to you to put the information, make the informa-
28 tion public so that people will know. After all, the
29 gasoline companies will tell you how much of it goes to
30 the Federal Government, how much of it goes to the



1 Province, how much of it goes to the retailer, how much
2 of it is taken up in the refinery, how much of it goes
3 to the crude. I happened to be through some of those
4 inquiries. I don't see why you are so concerned that it
5 will give aid and comfort to the enemy in the case of
6 the drug business.

7 MR. THOMPSON: It is not unusual for a
8 competitor to adopt a practice which has been proven
9 successful by someone who has experimented in this
10 industry. Marketing methods have been subject to great
11 change over the years. There have been philosophies in
12 this industry that the best way to sell drugs is by a
13 sales force unaided by advertising. Such a company was
14 the Upjohn Company at one time.

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1 MR. FRAWLEY: Now, Mr. Thompson...

2 MR. THOMPSON: In the opposite extreme
3 as already stated, I suggest you look at Smith, Klein and
4 French, a very successful company. They built their
5 business on direct mail and general advertising alone.
6 Over the years these two companies have changed their
7 methods. Now you can hardly tell them apart. They have
8 learned from each other's experience, I suppose.

9 MR. FRAWLEY: I have to leave that. I am
10 not going to leave it with a speech. I just note again
11 that I am very, very serious about it, you complained about
12 public opinion but you just have to live with it because
13 the public are not going to know what the make-up of your
14 prices are.

15 MR. THOMPSON: Unless they read the Green
16 Book.

17 MR. FRAWLEY: Now, Mr. Thompson, do you
18 sometimes sell to Federal or Provincial Departments?

19 MR. THOMPSON: Yes.

20 MR. FRAWLEY: You do that by responding
21 to requests for bidding?

22 MR. THOMPSON: Yes.

23 MR. FRAWLEY: You do that, of course, by
24 generic name?

25 MR. THOMPSON: That depends on what you
26 mean by generic names. If you mean the product which we
27 would furnish has the generic name on the label, then the
28 answer is yes.

29 MR. FRAWLEY: As I understand it and all I
30 know is what this record shows, the government departments



1 when calling for prices, calling for quotations specify
2 their requirements in generic, using generic names.

3 MR. THOMPSON: Yes, they sometimes do.
4 They frequently do. When our product is offered is the
5 product that we make. It is made to our standards and
6 normally exceeds the standard required by the invitation
7 to tender.

8 MR. FRAWLEY: I haven't any doubt about that.
9 Now, do you do that without any consultation with the
10 other bidders when you are quoting on these drugs?

11 MR. THOMPSON: Oh yes, indeed.

12 MR. FRAWLEY: You know, of course, that the
13 practice of applying for quotes results in competition among
14 the bidders.

15 MR. THOMPSON: We face competition in every
16 sale we make, Mr. Frawley, it is not a new experience.

17 MR. FRAWLEY: I will ask you something about
18 that in just a minute. You might be interested a little
19 bit in the information I will give. The Alberta Department
20 of Health called for tenders in Penicillin G 1961. They
21 were asking for a quote on 400,000 tablets of Penicillin G.
22 From British Drug House \$2.08; from Ayerst \$2.15; from
23 Glaxo, \$1.75; from Horner, \$2.00; from Frosst they got
24 \$2.25 and from Wyett \$2.34.

25 THE CHAIRMAN: Per hundred?

26 MR. FRAWLEY: Per hundred. To me that
27 indicates that these people when going out for government
28 contracts they come up with different prices. It means that
29 if it means anything at all. I put it to you that is
30 commendable. Would you agree?



1 MR. THOMPSON: You are asking me again
2 to comment on my competitors' practices. I didn't hear
3 you mention the name of our company.

4 MR. FRAWLEY: I must not be led down that
5 path. I am asking you whether or not you have ever quoted?
6 I am simply putting it to you this instance. I can't rub
7 Alladin's Lamp and find Lederle's quotations. We don't
8 seem to have wanted any of your products. Perhaps that
9 may be. I don't know. That is something else entirely.
10 Have you found in some of the experiences that you have
11 had, whether you have obtained a contract or lost a contract,
12 have you not been aware of the fact that your competitor's
13 bid, when they are bidding under generic name, they bid
14 at a variety of prices and the man with the lowest bid gets
15 the contract.

16 MR. THOMPSON: Again, Mr. Frawley, I think
17 it is very unfair for you to ask me to speak for my
18 competitors' practices. I know what my company does.

19 MR. FRAWLEY: You don't understand me at all.

20 MR. THOMPSON: You are not getting through.

21 MR. FRAWLEY: Put Penicillin G aside. You
22 have told me you have bid on Government contracts, Lederle
23 has bid on Government contracts?

24 MR. THOMPSON: Yes.

25 MR. FRAWLEY: All right. In those instances
26 has it not been the fact or has it been a fact that the
27 Government Department has received a variety of bids?

28 MR. THOMPSON: Well, Mr. Frawley, from my
29 memory -- I didn't bring the records to talk from. It is
30 probably true. I can certainly say that.



1 MR. FRAWLEY: Now, that practice does not
2 exist at all when you are selling to the retailer?

3 MR. THOMPSON: The Government asks for
4 different services than those, the Federal Government when
5 a sale is made it is different, with different requirements,
6 different services required from the company. It will
7 certainly affect the prices.

8 MR. FRAWLEY: The merchant, the druggist on
9 the corner has nothing to do but to accept your list price
10 less 40%? He has no more elbow room than that? Am I right
11 wrong in that statement?

12 MR. THOMPSON: That is true, Mr. Frawley,
13 but let me add and I think you should recognize the fact
14 it is not the pharmacist that makes the choice of the
15 product for the patient. The decision is the physician's.
16 The physician, as I indicated to you yesterday does have a
17 choice and is always interested in price and very sensitive,
18 we find.

19 MR. FRAWLEY: He has no choice at all if he
20 wants Achromycin from the list plus discount.

21 MR. THOMPSON: As I indicated to you
22 Achromycin is not the only alternative.

23 MR. FRAWLEY: We are talking about two
24 different kinds of competition. Certainly I understand
25 Achromycin is competing in the physician's favour with....

26 MR. THOMPSON: Penicillin.

27 MR. FRAWLEY: The tetracyclines I mentioned.

28 MR. THOMPSON: And chloramphenicol and
29 penicillin and erythromycin and other antibiotics.

30 MR. FRAWLEY: All of which will be at the



1 price less discount.

2 MR. THOMPSON: Penicillin?

3 MR. FRAWLEY: With Penicillin?

4 MR. THOMPSON: Of course.

5 MR. FRAWLEY: You say he has to compete
6 against penicillin?

7 MR. THOMPSON: Yes.

8 MR. FRAWLEY: I am talking about broad
9 spectrum antibiotics.

10 MR. THOMPSON: Why should we? The physician's
11 choice is not limited to broad spectrum antibiotics.

12 MR. FRAWLEY: Is it your answer then that
13 low spectrum, the narrow spectrum antibiotics are in
14 competition with the broad spectrum antibiotics.

15 MR. THOMPSON: Most assuredly.

16 MR. FRAWLEY: Assume with me that the
17 doctor is looking for broad spectrum antibiotics. It
18 happens to be a fact which I am told is very common
19 procedure. The druggist does not have any opportunity,
20 the retail druggist to ask you what you charge him and
21 then ask Squibb what he would charge him for this drug
22 and so on down the line for these three or four major
23 broad spectrum antibiotics.

24 MR. THOMPSON: We have 4,860 pharmacists
25 as direct markets -- those are the drug stores in which
26 our products are stocked. That is what I meant to say.
27 Would you suggest we should set up a mechanism for in-
28 dividual quoting to each of the stores every time they
29 had a prescription? I am sure you would agree that is

30



1 extreme.

2 MR. FRAWLEY: I am reminded, I don't want
3 to burden the Commission, something I have already done,
4 I am reminded of the editorial in Edmonton Journal, one
5 of Canada's great newspapers in which they declared the
6 fact there was no discipline in the market place, discipline
7 in the market place had disappeared from the merchandising
8 of drugs. Do you think the Edmonton Journal editorial
9 was wrong?

10 MR. THOMPSON: I don't understand the mean-
11 ing of that statement. You will have to explain it to
12 me.

13 MR. FRAWLEY: The price that is given,
14 \$43.13 has not been hammered out in the series of conferences
15 between the retailers and Lederle.

16 MR. THOMPSON: You mean ...

17 MR. WAHN: Is my friend suggesting it
18 should be in view of the legislation which exists?

19 MR. FRAWLEY: The combines legislation --
20 it is strange enough that you get very enthusiastic in
21 your competition prices, in quoting different prices in
22 looking for Government contracts. As far as Lederle is
23 concerned, if my friend says this is one of the effects
24 of the Federal Statutes, well the drug industry has got
25 its all nice and fenced off. That is all. You say it
26 would prevent, the law would prevent you from saying to
27 a drug store well this man seems to be an enterprising
28 sort of fellow, he wants to know what our best price is.
29 I will just quote him something less than list, five or
30 ten off list.



1 MR. WAHN: I think ...

2 MR. FRAWLEY: Excuse me, five or ten per
3 cent more than the standard 40%?

4 MR. THOMPSON: Mr. Frawley, I have been
5 advised that would be a flagrant violation of the Combines
6 Legislation.

7 MR. FRAWLEY: That is another thing that
8 adds to the difficulties of merchandising of drugs and
9 simply permits you to fix your price whether by combina-
10 tion or otherwise. Don't misunderstand me, I am not making
11 any allegations. The fact is you and Squibb and the rest
12 of the people concerned, that is all I refer to, quote
13 the same list price in the whole series of broad spectrum
14 antibiotics. There is no way of the retailer bringing
15 them down by asking you to make a difference in his case.

16 MR. THOMPSON: Mr. Frawley, if you or anyone
17 in Alberta buys fuel oil or natural gas to heat his house
18 I am sure he would find the prices of that product are the
19 same and for the same reason.

20 MR. FRAWLEY: As far as I am concerned, I
21 say with the greatest respect when you say fuel oil you
22 are talking about one of the major products of our province,
23 I certainly am not going to compare with you the buying
24 of fuel oil or gasoline with the purchasing of these
25 life-saving drugs because that is all I am talking about.

26 MR. THOMPSON: Let us compare methods by
27 which price identity is established. That is what you
28 are asking about.

29 MR. FRAWLEY: That is true. I say there
30 should be some way of getting down the price particularly



1 when you are able to get the price down when you are
2 quoting on Government departments. Why should the
3 Government of Alberta be able to buy Penicillin G for
4 two cents a tablet when the man who buys it in the drug
5 store has to pay nineteen and a half cents a tablet? That
6 is all. Why? The Alberta Government has plenty of money.
7 Why don't they pay? Why does the man who goes in, the
8 marginal income man, why does he have to pay high prices
9 when the Alberta Government and the Government of Canada
10 can buy at these low, low prices?

11 MR. THOMPSON: I have already commented on
12 competitors' prices. Please don't ask me again.

13 MR. FRAWLEY: Perhaps you would agree with
14 me that the retail sales -- what would directly be the
15 percentage of what you sell over the retail counter and
16 what you sell to government departments at these low
17 competing prices?

18 MR. THOMPSON: You have asked two questions.
19 You have inferred that our company has low bid prices. I
20 would like to comment on that, Mr. Frawley, because you
21 have challenged me. We do quote low bid prices, about
22 25% lower than the price at which we sell to the retail
23 drug store. I have no apology to offer for that. It
24 is a question of quantity.

25 MR. FRAWLEY: What would you sell to the
26 retailer?

27 MR. THOMPSON: I can't tell you from memory
28 the percentage. It varies according to the product and it
29 varies from month to month, the percentage of our mer-
30 chandise which is sold to the Federal or Provincial



1 Government and that sold to the retail outlets. It would
2 be a far higher proportion sold through the retail outlets.
3 I would be glad to furnish details to the Commission in
4 confidence if they wish.

5 MR. FRAWLEY: Would you think there is some
6 cross subsidizing in drug merchandising?

7 MR. THOMPSON: There isn't in our company.
8 I don't want to speak for our competitors. We don't
9 cross subsidize.

10 MR. FRAWLEY: You don't think the retail
11 counter prices are subsidized in the low prices to hospitals
12 and government departments and mental institutions and so
13 on.

14 MR. THOMPSON: No, our company, the pricing
15 practices of our company depend on the services which we
16 render, which we believe are needed and appreciated and
17 if there are services which create the demand for a worthy
18 drug we charge for those services.

19 MR. HALL: One question or two, my learned
20 friend has commented on the differences between retail
21 prices on drugs and prices to institutions. Would it not,
22 Mr. Thompson, be pertinent to observe, perhaps for the
23 thousandth time, there is a 40, 50% differential that
24 consists of the pharmacist's mark-up?

25 MR. THOMPSON: Oh, of course. I assumed
26 this was understood. Thank you.

27 MR. FRAWLEY: Now, Mr. Thompson, you took
28 an exception to the statement made by Dr. Ross, Minister
29 of Health to the Commission in Edmonton with regard to
30 what he thought would be the benefit; namely and I quote



1 from his suggestion:

2 "It is suggested that the Commission should
3 look into 1: The possibility of changes in
4 Federal and Provincial legislation which
5 would permit the pharmacist properly to
6 dispense the generic equivalent even when a
7 trade name drug is mentioned in the
8 prescription unless the doctor specifically
9 states that only the trade name drug is to
10 be provided."

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1 I am not too clear what, because I didn't
2 make a note unfortunately of what your objection was to
3 that suggestion by the Minister of Health.

4 MR. THOMPSON: This suggestion, Mr. Frawley,
5 is, as I understand it, based on the theory that any
6 supplier of a drug is equal to any other supplier for
7 usefulness to the community, and that therefore they
8 should be compared on an equal basis.

9 That is to say, that a creator, a company
10 which is creatively oriented - and by that I mean with
11 research and marketing facilities - should be treated as
12 equal to the company which merely waits until the drug
13 has been developed, the market created, and then comes
14 in and seeks to supply a portion of that market without
15 incurring the costs of the creative effort. This theory,
16 Mr. Frawley, says therefore that creative effort is
17 undesirable in the drug industry.

18 MR. FRAWLEY: What is?

19 MR. THOMPSON: Undesirable.

20 MR. FRAWLEY: Creative effort?

21 MR. THOMPSON: Yes, and the drug industry
22 is well able to respond to that type of philosophy, but
23 I suggest to you that it would be a great disservice to
24 the people of Canada if it were brought about.

25 MR. FRAWLEY: Now, just so we will be sure,
26 I want to read from Dr. Ross' evidence before the Commis-
27 sion in Edmonton in Volume 9 of July 24 1961. It is at
28 page 866 and he says:

29 "It is suggested that the Commission should
30 look into:-



1 (1) the possibility of changes in
2 federal and provincial legislation which would
3 permit a pharmacist properly to dispense a generic
4 equivalent even when a trade name drug is mentioned
5 on the prescription unless the doctor specifically
6 states that only the trade name drug is to be pro-
7 vided.

8 I may say, sir, that this practice
9 is being carried with the approval of the medical
10 staffs of many of the hospitals in Alberta today
11 to the benefit of the economy of the provision of
12 drugs under our programmes.

13 THE CHAIRMAN: Do you mean by that
14 that where a physician prescribes a drug by a trade
15 name the pharmacist is considered at liberty to
16 supply an identical drug that may be made by some-
17 body else and it may have a different trade name or
18 they can supply the same generic drug?

19 DR. ROSS: Yes, that is correct.
20 That has been carried out with the consent of
21 members of the medical staff rather than have a
22 multiplicity of drugs on the medical shelves. So
23 if the drug is the same, even though the trade name
24 is not the same, it may be used.

25 THE CHAIRMAN: We have been told that
26 a pharmacist has no choice, even though it is on
27 the prescription, that that is what he must supply.
28 It is interesting to note the variation in Alberta".

29 I want you to comment on that, having read
30 the whole of the text of what Dr. Ross said and what the



1 Chairman said, but before that I want to put it to you
2 that there is nothing exceptional or original in the
3 practice that is going on in the hospitals of Alberta,
4 is there?

5 MR. THOMPSON: I have heard it suggested,
6 Mr. Frawley, that if the ingredients in the preparation
7 are the same as the ingredients in a preparation which
8 my company might make, that a retail pharmacist or a
9 hospital pharmacist is competent to say these are inter-
10 changeable.

11 I can give you many examples of where it
12 is not so, and not so in a dangerous way, and I will give
13 you a specific example, Mr. Frawley, of why I think that
14 is a very dangerous practice, and why that is a sure way
15 to stifle creative effort.

16 There are two companies functioning in
17 Canada, and they are manufacturing plants. They are both
18 competitors of mine. They both make antibiotic ointments.
19 Each ointment contains the same antibiotic according to
20 the label, in either the same or very similar strength.

21 One of these ointments is made with a petro-
22 latum base which is a grease base which will not mix with
23 water, and I am sure you know how effectively petrolatum
24 substances repel water.

25 The other company formulates the antibiotics
26 in a base which mixes with water instantly which creates
27 a rapid transfer of the antibiotic from the ointment into
28 the fluid at present in an injury, and there is a clinical
29 difference, an easily detected clinical difference in the
30 rate of reaction, in the rate of healing that each of



1 these antibiotics create.

2 If you read the generic names off the
3 labels, you won't be able to tell them apart, and neither
4 would a pharmacist in a hospital in Alberta, and yet the
5 effect on the patient is substantially different. I
6 think the physician should be given the right to disagree,
7 and you are suggesting it should be denied him.

8 MR. FRAWLEY: I put it to you, there is
9 nothing original about what is going on in the Province
10 of Alberta, and I won't be led into any discussion about
11 what happens in the hospitals in Alberta. You have your
12 own opinion about the confidence of the medical staffs
13 in the hospitals of Alberta and it is not for me to say
14 one single thing about that.

15 However, I put it to you that it was not
16 original and it was an accepted thing, and I want to
17 read page 238 of the Kefauver Report of June 27 1961
18 speaking of the formulary system:

19 "Under this practice, hospitals make their
20 purchases in terms of generic names; all
21 physicians making use of their facilities
22 signify in writing their willingness to
23 have such drugs employed on their patients
24 even if prescriptions actually specify
25 trade names. In this country the hospital
26 formulary was adopted at the New York
27 Hospital in New York City as early as
28 1816. At that time trade names were
29 virtually unknown; the hospital's interest
30 was primarily in ensuring a rational drug



1 therapy. This view still prevails."

2 I want to read to you from a document that
3 accompanied a letter which I received from Dr. Martin
4 Cherkasky, the Director of Montefiore Hospital in New
5 York City in which he sent me a copy of his testimony
6 that he gave appearing before a Committee of the Senate
7 that was considering Senator Kefauver's Bill No. S1552,
8 and he says:

9 "What goes for the public's attitude
10 towards hospital costs, applies as well
11 to drug costs. The public has no choice
12 but to fill the doctor's prescription,
13 but the skyrocketing costs have caused
14 anguish and organized consumer groups
15 are seeking all sorts of ways to minimize
16 drug prices. One of the ways which hospi-
17 tals and increasing numbers of consumer
18 groups have found effective is the well-
19 known formulary system. Sixty per cent
20 of the hospitals in the country of 100
21 beds or over restrict the prescribing of
22 drugs to those approved by the pharmacy
23 committee, composed of experts in clinical
24 medicine and pharmacology. New drugs are
25 carefully reviewed, some are included in
26 the formulary, some are not. This profes-
27 sional and controlled method of the pres-
28 cribing of drugs in hospitals lowers
29 pharmacy costs. Inventories are kept to
30 satisfactory minimums and the pharmacy



1 can purchase drugs from competent manu-
2 facturers on generic rather than brand
3 name basis. Doctors are urged to pres-
4 cribe by generic name, but if not, the
5 hospital is authorized to substitute an
6 equivalent drug.

7 My pharmacist informs me that we save
8 about \$75,000 a year as a direct result
9 of a tightly controlled formulary system.
10 However, not more than 45% of our ethical
11 drugs are purchased on a generic basis.
12 This represents but 24% of our dollar
13 volume. Therefore, of the \$315,000 now
14 in our pharmaceutical budget, \$240,000
15 reflects brand name purchases. Signifi-
16 cantly, 90% of our dollar volume for the
17 'big three' - antibiotics, hormones, tran-
18 quilizers - must be bought on a brand name
19 basis amounting to \$122,000 a year. There
20 is no question that major savings would
21 occur, possibly up to 40% of our total
22 annual expenditure of \$315,000, if we
23 could do all our buying by sending out bids
24 on a generic basis to all manufacturers
25 including the reliable small ones".

26 And then he quotes:

27 "I asked my pharmacist to list for me
28 some commonly prescribed drugs at the
29 hospital that we buy generically together
30 with our cost and the list price of the



1 equivalent brand name item. I would like
2 to cite these examples for you to give
3 you an indication of the savings which
4 accrue when brand names are bypassed.

5 Non-Proprietary List Price

6 Name Trade Name Unit Cost of Trade Name

7 Diocetyl Sod.
8 Sulfosuccinate Colace 1000 \$7.00/M \$53.32/M
9 Hydrocortisone
10 Neomycin Oint. Neo-Cortef 20 Gms. 1.20 3.33
11 Methenamine
12 Mandelate Mandelamine 1000 6.00/M 14.60/M
13 Pentobarbital.
14 Sod. Nembutal 1000 3.50/M 16.20/M
15 Prednisone Meticorten 1000 11.50/M 170.00/M
16 Theophyllin
17 Ephed. Comp. Tedral 1000 4.50/M 24.00/M"

18 MR. THOMPSON: That is not an ephedrine
19 compound, Theophyllin.

20 MR. FRAWLEY: What is that?

21 MR. THOMPSON: That is not a Theophyllin
22 ephedrine compound.

23 MR. FRAWLEY: "Theophyllin, Ephed. Comp."

24 MR. THOMPSON: Yes but it includes pheno
25 barbital which is not mentioned there and that might be
26 a very dangerous combination.

27 MR. FRAWLEY: He just quotes the non-proprie-
28 tary name.

29 MR. THOMPSON: That is not an accurate non-
30 proprietary name for that preparation.



1 MR. FRAWLEY: " ---

2 Theophyllin

3 Ephed. Comp. Tedral 1000 4.50/M 24.00/M

4 Tetracycline Achromycin 100 17.60/C 25.88/C"

5 I have gone to the trouble of putting all
6 that into the record to indicate to you that these hospi-
7 tals in New York and elsewhere in the United States and
8 our own hospitals in Alberta - and I would be surprised
9 if we were the only hospital in Canada where this practice
10 has been adopted with the prescribing of drugs to an in-
11 patient through the hospital formulary system, and I say
12 it does not endanger the well-being or the treatment of
13 those patients in the Alberta hospitals one iota, Mr.
14 Thompson, and I don't suppose you would challenge that
15 statement.

16 MR. WAHN: I don't think Mr. Thompson should
17 be asked to comment or to challenge that statement.

18 MR. FRAWLEY: Except that he spent some time
19 indicating the dangers, the watering down, and I am only
20 giving a very layman's interpretation of what Mr. Thompson
21 said.

22 THE CHAIRMAN: I am wondering if Mr. Thomp-
23 son is in a position to base any considered opinion upon
24 what is actually being done in Alberta.

25 MR. FRAWLEY: Then, Mr. Chairman, of what
26 value, with respect to my friend and to his witness, is
27 the comment that has already been put on the record,
28 because if it was not for that, I would not have put my
29 comment on the record with regard to the serious conse-
30 quences that come from prescribing by generic names in



1 hospitals? That is my answer. It is for the Commission
2 to decide.

3 THE CHAIRMAN: I am just wondering if Mr.
4 Thompson is in any position to give a considered answer.

5 MR. FRAWLEY: I am wondering if he was in
6 any position to make the statement he made ten minutes
7 ago before I put my question to him. Thank you very
8 much, Mr. Thompson.

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T/EMT/hm

1 MR. THOMPSON: Mr. Frawley, just to extend
2 this one notch further, I made the comment that substitu-
3 tion of a supposedly equivalent preparation -- you read
4 one there that was not equivalent from your list of a
5 knowledgeable source -- could indeed be dangerous. I
6 didn't say it was dangerous. I said it could be dangerous.
7 That is I think the comment that I put into the record.

8 MR. FRAWLEY: I suppose that these hospitals
9 that adopt the formulary system are aware of the degree
10 of danger there is. I put it to you in all seriousness
11 if there were any real danger, the university hospital
12 in the City of Edmonton would not be having any part of
13 it. I cannot say anymore than that.

14 MR. THOMPSON: Mr. Frawley, you are suggesting
15 a principle here that I think deserves further comment,
16 and that is -- I repeat it to you -- that the creatively
17 oriented company, the company that creates progress in
18 the drug field in hemotherapy should be expected to compete,
19 penny for penny, price for price with an imitator. This
20 is the principle that you have enunciated. This is a
21 method by which this industry can be expected -- can be
22 made to function in Canada. The method that you are
23 describing can be brought about.

24 My company is quite capable of operating
25 under the philosophy, but I assure you unequivacably you
26 will bring to a grinding halt all new development of drugs
27 under that system. Who will invest money to bring these
28 products to the attention of the doctors of Alberta. Would
29 the Government of Alberta be willing to do the promotional
30 effort, and if not, why should my company do it?



1 I am going to be asked to compete with an
2 imitator who can produce this in carload lots. Why should
3 I promote it to bring it into use and lose the opportunity
4 for reward resulting from my effort?

5 MR. FRAWLEY: Of course I don't like the
6 use of the word -- you used the word "imitator" very
7 glibly, Mr. Thompson. I am putting against it the record
8 of the Ottawa Civic Hospital. Dr. Schechter appeared
9 before the Commission and talked about the formulary
10 system, and Dr. Ross appeared before the Commission and
11 talked about the formulary system in Ottawa. Dr.
12 Cherkasky talked about the formulary system in the big
13 Jewish hospital in New York City, and you are saying all
14 these people are treading on dangerous ground.

15 MR. THOMPSON: There are two kinds of
16 manufacturer; one is the creator and the other is an
17 imitator, and I don't know of any other kind.

18 MR. FRAWLEY: The question is whether the
19 public can afford this creation.

20 MR. THOMPSON: I guess it is a question of
21 the public wanting new drugs. What about the cancer cure?
22 My company has invested a great deal of money, millions of
23 dollars, every year towards the discovery of a treatment
24 for cancer. We could stop that; we could remove that
25 content out of our price structure if this would make you
26 happy. All we need to do is change the rules.

27 MR. FRAWLEY: No, it wouldn't make me happy
28 at all, and I don't think it needs any change at all. It
29 wouldn't make any difference to you, but it is only my
30 opinion against yours, but in the balance is the experience



1 of these hospital people. That is what is in the balance.

2 THE CHAIRMAN: Have you finished?

3 MR. FRAWLEY: Yes, thank you very much.

4 THE CHAIRMAN: I think we had better adjourn
5 for lunch. Quarter to one. We will resume at 2:15.

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8 ----Luncheon adjournment.

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A/Emt/hm

1 ---Upon resuming at 2:15 p.m.

2 THE CHAIRMAN: Mr. MacLeod?

3 MR. MacLEOD: Yes, sir. Mr. Thompson,

4 before we start, perhaps you will permit me to say on
5 behalf of the Director that we are extremely grateful both
6 to you and to your firm for coming here and making the
7 information which you have available. I cannot speak for
8 the Commission of course, but I am sure it will be of great
9 assistance to them to have a manufacturer who knows the
10 business come here and testify.

11 Now, we may not agree on everything we
12 discuss this afternoon, but I do want you to know we
13 appreciate your coming forward and putting your views on
14 record.

15 Is your company still in the fine chemical
16 business?

17 MR. THOMPSON: That is correct, Mr. MacLeod.

18 MR. MacLEOD: In addition to the drug
19 business?

20 MR. THOMPSON: Yes.

21 MR. MacLEOD: And do you still produce
22 dosage forms of various drugs for other drug companies,
23 such as Penicillin injections and things of that kind?

24 MR. THOMPSON: We have done this in the
25 past, Mr. MacLeod. I am not familiar in detail with our
26 present activities. We do not produce penicillin at the
27 present time.

28 MR. MacLEOD: When you did in the past pro-
29 duce dosage forms for other companies, did you import those
30 from the United States, or did you manufacture them in



1 Canada?

2 MR. THOMPSON: Well, Mr. MacLeod, I have
3 not been associated with that phase of the company's
4 activities, and I am afraid I cannot answer it, but we
5 would be willing at any time to quote on manufacturing a
6 preparation that comes within the scope of our facilities
7 for a competitor.

8 MR. MacLEOD: Yes. Now, there was some
9 discussion this morning about the cost of tetracycline.
10 Have you read the report of the Kefauver Committee?

11 MR. THOMPSON: No, I have not, Mr. MacLeod.

12 MR. MacLEOD: I would like to draw your
13 attention to chart 1 which appears on page 23, and on the
14 following page there are certain details which would appear
15 to indicate that in the prices of -- what are the companies,
16 Bristol and Upjohn?

17 THE CHAIRMAN: Are the companies mentioned
18 there, Bristol and Upjohn?

19 MR. THOMPSON: Yes. Was there a question,
20 Mr. MacLeod?

21 MR. MacLEOD: Yes. My question was whether
22 the companies mentioned are Bristol and Upjohn?

23 MR. THOMPSON: Yes, I beg your pardon.

24 MR. MacLEOD: I now have a copy of the
25 report before me, and I can see that. The chart would
26 indicate that in the case of Bristol, the total cost of
27 the bulk tetracycline and of capsuling and finishing the
28 package of 100, 250-milligram capsules is \$2.88. In
29 addition to that the company pays royalties of \$2.15,
30 making a total of \$5.03 as the cost of 100 capsules.



1 That would indicate that in the United States at least
2 the price of tetracycline is considerably below the figure
3 that was discussed between you and Mr. Frawley this
4 morning.

5 MR. THOMPSON: You are thinking now in
6 reference to Bristol or Upjohn?

7 MR. MacLEOD: Yes.

8 MR. THOMPSON: Well, if these data are
9 accurate, and I assume they are gathered by some official
10 agency, that appears to be true.

11 MR. MacLEOD: You spoke in your brief I
12 think of Cyanamid discovering tetracycline. The patent
13 on tetracycline is held by Pfizer, is it not?

14 MR. THOMPSON: In which country, Mr. MacLeod?

15 MR. MacLEOD: In Canada.

16 MR. THOMPSON: That I don't know. I am
17 sorry. My company is a licensee in Canada.

18 MR. MacLEOD: Is a licensee of whom?

19 MR. THOMPSON: American Cyanamid.

20 MR. MacLEOD: So that any arrangements beyond
21 that would be a matter for the parent company?

22 MR. THOMPSON: Yes. I would like to answer
23 your questions, but I just don't know.

24 MR. MacLEOD: Have you read the economic
25 report on antibiotic manufacture which you refer to in
26 your brief?

27 MR. THOMPSON: No, I have not. I just had
28 some passages brought to my attention which are in the
29 brief, and I had not read it. I have not interested myself
30 particularly in the American economic situation.



1 MR. MacLEOD: Now, in your brief you point
2 out that the Director is in error in accepting these
3 statements from a Ph.D thesis in respect to certain promo-
4 tional expenditures. That was sampling was done for
5 Aureomycin.

6 MR. THOMPSON: I hope I did cast aspersions
7 on the Director. I realize he quoted from a source for
8 which he was not responsible. I merely tried to indicate
9 that the facts in the source which the Director quoted
10 appear to be inaccurate.

11 MR. MacLEOD: Yes. Do you know how many
12 tablets each doctor received in that sampling?

13 MR. THOMPSON: No, Mr. MacLeod, I do not.
14 I was not with the company at that time.

15 MR. MacLEOD: How many tablets or capsules
16 I should say in this case do you normally distribute when
17 you distribute a sample of terramycin?

18 MR. THOMPSON: It is some time since we
19 distributed any terramycin. That is a Pfizer product.

20 MR. MacLEOD: I mean Aureomycin, I am
21 sorry.

22 MR. THOMPSON: We don't sample Aureomycin
23 except in rare cases. Sampling generally has regard for
24 the circumstance in which the sampling is done. In other
25 words, I think I referred to the case of the Dale family
26 in Ottawa, and in that situation we furnished substantial
27 sized packages of Aureomycin syrup.

28 A physician who expresses an interest in
29 applying one of our antibiotics to a treatment, to a
30 specific patient, generally receives a sample commensurate



1 with his need in that situation. A very frequent size is
2 a bottle of 16, for declomycin in particular.

3 MR. MacLEOD: Have you sampled tetracycline
4 lately?

5 MR. THOMPSON: Yes.

6 MR. MacLEOD: What would be the normal
7 sample that you would furnish a physician?

8 MR. THOMPSON: There are again samples,
9 packages of 16, and it is also available in other dosage
10 forms, injectable and liquid dosage forms also.

11 MR. MacLEOD: Yes. Would I be correct in
12 assuming that at the time tetracycline was brought on the
13 market, the first dosage form that was developed was 250
14 milligram capsules?

15 MR. THOMPSON: It would be difficult for me
16 to confirm that categorically, Mr. MacLeod, because I
17 was not with the company at that time, but it sounds
18 reasonable.

19 MR. MacLEOD: That was the principal dosage
20 form initially in the case of all of these broad spectrum
21 drugs, was it not?

22 MR. THOMPSON: In all likelihood I would
23 expect it to be, yes.

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rw/dpw

1 MR. MACLEOD: I was just trying to learn,
2 if I can, your estimate of the cost of the \$1.25 for
3 each doctor.

4 MR. THOMPSON: I obtained that figure from
5 the Advertising Manager of Lederle Laboratories in Pearl
6 River. He had been concerned about this apparent inaccu-
7 racy in the source which the Director quoted. It seemed
8 to me that it should be set right.

9 It was repeated in the Director's Statement
10 and I think it was read back in testimony before the
11 Commission and it prompted us to investigate it, so I
12 simply asked my colleague in the United States if it is
13 accurate. He said no and gave me the correct figure.

14 MR. MACLEOD: The record will show, I think,
15 that the retail price, the consumer's price, the list
16 price at that time was \$21.40 for 16 capsules.

17 MR. THOMPSON: You mean the retail price?

18 MR. MACLEOD: The retail price.

19 MR. THOMPSON: That may well be Mr. MacLeod.
20 You have presumably checked that. I haven't.

21 MR. MACLEOD: Well just before we leave
22 that, the example which the Director cited is obviously,
23 for the reason you have stated, incorrect, but it should
24 perhaps be noted that there is another reference to
25 expenditures, promotional expenditures in the promotion
26 of Aureomycin which is quoted on page 115 of the Statement
27 and that is an affidavit by the President of the American
28 company, Dr. Malcolm, that Cyanamid had expended
29 \$20,000,000 up until October 4th 1955. There was another
30 matter in connection with the Statement. You mentioned



1 that because of the way the Director's question was
2 framed that your company did not include expenditures
3 by your parent company in Canada, is that correct?

4 MR. THOMPSON: Yes, that is correct.

5 MR. MACLEOD: Now would these expenditures
6 be on the projects by the American company itself? That
7 is, having a Canadian doctor carry out some research or
8 testing of the product, or something like that?

9 MR. THOMPSON: It would be hard to answer
10 that yes or no, but I would be glad to explain it as I
11 see this working in day-to-day business.

12 Dr. Warminton, my colleague, has as his
13 principal responsibility, the seeking out of qualified
14 clinical investigators in Canada who have interests,
15 facilities or skills in specialized areas of medicine.
16 Another part of Dr. Warminton's duties is to maintain
17 regular contact with the medical department of the
18 American company to seek out the projects, the new drug
19 propositions in which they are interested and those which
20 appear most promising, and then to match up by visiting
21 Pearl River in the United States, the appropriate clinical
22 investigators in Canada, the possibility of having a study
23 conducted under efficient circumstances, when suitable
24 contact is established which is mutually interesting.
25 Then the American company would frequently make funds
26 available to defray the cost of that clinical study and
27 by that I mean not to pay the clinician a professional
28 fee but merely to defray the additional expenses beyond the
29 normal treatment of the patient which would be needed to
30 seek information about the drug, such things as laboratory



1 tests which might be needed in a hospital that would not
2 normally be ordered in the treatment of the disease which
3 were necessary by reason of the new drug, in order to
4 evaluate it.

5 Frequently the clinical investigator keeps
6 records which he might not otherwise need for the normal
7 treatment of the patient and it is frequently the case
8 that the cost of this clerical work will be included in
9 a grant, grant in aid so that these grants are made
10 on the recommendation of ourselves in Canada when we
11 believe that useful, new information may be developed on
12 an embryonic new drug.

13 MR. MACLEOD: My point in raising it with
14 you Mr. Thompson is simply this: obviously in this parti-
15 cular case because we did not ask you the right question
16 we did not get complete information. Now as a man in the
17 industry do you think that there is much of this type of
18 work being carried on in Canada that we would not have
19 learned of simply because we went to Canadian companies
20 or branches located in Canada?

21 MR. THOMPSON: Well Mr. MacLeod it is a little
22 difficult for me to answer for my competitors' practices,
23 but I can say this that there is within the Canadian
24 Pharmaceutical Manufacturers' Association, there is a
25 medical directors' section, medical section which is made
26 up of the medical directors of the member companies.

27 Now this Association has, as you will no
28 doubt be hearing shortly, has a membership of approximately
29 55 companies. There are, of course, many more companies
30 engaged in this business in Canada as the Dominion Bureau



1 of Statistics indicates but from among this membership,
2 this medical section has normally in attendance at
3 meetings some 25 medical directors drawn from these few
4 companies, and if Dr. Warminton is here he might be able
5 to elaborate - he is not in the room.

6 I recently attended such a meeting and
7 there were somewhere between 20 and 30 medical directors.
8 Now I would - well I know from our own contacts with
9 clinicians that other companies doing research also are
10 interested in the clinical facilities available in Canada
11 and they are very good facilities too, and therefore I
12 assume that there are a number of other companies following
13 the same general pattern of approach, so I would suggest
14 Mr. MacLeod that it might have been more meaningful if
15 the question had been framed around the total research
16 expenditures on behalf of the Canadian company whether
17 directly by that company or on its behalf by its asso-
18 ciated company in other countries.

19 MR. MACLEOD: In other words there is a
20 possibility that there may be other instances of research
21 expenditure that were not reported?

22 MR. THOMPSON: Oh I think very definitely,
23 and I think, if I remember the wording of the Director's
24 Statement, that one or more companies volunteered infor-
25 mation indicating that type of activity.

26 MR. MACLEOD: Yes.

27 MR. THOMPSON: You see, the inquiry directed
28 at our President was in reference to Cyanamid of Canada
29 Limited and it asked, in effect, how much did the company
30 spend and it was answered exactly as written by accounting



1 people.

2 MR. MACLEOD: You spoke this morning, I
3 think, of two reductions in price for Achromycin?

4 MR. THOMPSON: Yes.

5 MR. MACLEOD: When did this take place?

6 MR. THOMPSON: One reduction I think was -
7 I think there was evidence in my brief that the first
8 reduction of approximately 15% was announced on, I think
9 it was, October 24th. It is in the record Mr. MacLeod,
10 1960.

11 MR. MACLEOD: October 24th. In setting the
12 price for your products do you consult with the American
13 company?

14 MR. THOMPSON: Yes, we do indeed consult
15 with not just the American company but with other asso-
16 ciates in other countries of the world because these
17 preparations are marketed in many countries and we are
18 always interested in what we can learn about new competi-
19 tive situations which do not always arise for the first
20 time in Canada and by so doing keep ourselves alert and
21 prepared for competitive activity in this country.

22 MR. MACLEOD: Had there not in fact been
23 reductions in the United States prior to your reduction
24 in Canada?

25 MR. THOMPSON: Yes, there was a reduction.
26 In this situation indeed there was a reduction in the
27 United States.

28 MR. MACLEOD: Do you know if the reduction
29 in the United States was started by Pfizer?

30 MR. THOMPSON: Well I can repeat a little



1 of the hearsay which has come to me through my associates.
2 My understanding is, and I hope this will go into the
3 record as my own impression.

4 THE CHAIRMAN: It is going in as hearsay
5 I think.

6 MR. THOMPSON: Indeed it is hearsay. The
7 Pfizer Company decided to offer an additional discount
8 to retail druggists, possibly in the belief that druggists
9 could influence the sale of the Pfizer antibiotics. Our
10 company does not, certainly myself and my colleagues I
11 think agree, that in our view this is unlikely to
12 influence the volume of business.

13 The Squibb Company - again this is hearsay -
14 decided to match Pfizer's move by making available a
15 similar additional discount but they did so through whole-
16 salers. This resulted in a reduced price at the point
17 where the drug enters the drugstore, and then I understand
18 that the Upjohn Company which does not recognize whole-
19 salers in its marketing policy, reduced its direct selling
2 20 price and this I think was met by Pfizer with reduced
21 list price and all companies immediately met this list
22 price.

23 MR. MACLEOD: Was that a factor in the
24 reduction in Canada, the fact that prices had been
25 reduced in the United States?

26 MR. THOMPSON: Yes. I reasoned that it was
27 not right for a reduction to be made in the United States
28 that should not also be made in Canada and we reached the
29 decision in Canada to make a similar reduction here and
30 we were the first company to do so. I think I have



1 related the events which followed that decision.

2 MR. MACLEOD: Yes. What you say you say
3 is hearsay, but it is in fact confirmed by the evidence
4 of Lyman Duncan, who is, I believe, an official of your
5 company, the American company?

6 MR. THOMPSON: Yes. It was Mr. Duncan to
7 whom - with whom I discussed this.

8 MR. MACLEOD: Mr. Duncan in evidence on
9 September 8th 1960 before the Kefauver Committee, and
10 this appears at page 13728 of Part 24 ---

11 MR. THOMPSON: I hope I have been accurate
12 in my recollection.

13 MR. MACLEOD: Well, Mr. Duncan is reported
14 to have said:

15 "Pfizer was the first company that made the
16 move. They reduced - let me take a moment -
17 they reduced the price to direct accounts
18 by 15 percent" -

19 and then there is some discussion. He is not sure of his
20 figures -

21 "Now we followed that. This happened on a
22 Saturday. They tried to steal a march on
23 the industry, I guess. They sent out tele-
24 grams to the trade on a Saturday.

25 Senator KEFAUVER: They tried to do what?

26 Mr. DUNCAN: Steal a march on the rest of the
27 industry, I suppose, because they did this
28 on a Saturday.

29 Senator KEFAUVER: You mean after 10 years of
30 operation, they should suddenly steal a



1 march on you?

2 Mr. DUNCAN: Yes, Senator".

3 So apparently the story is as you related
4 it. You say that was a factor in the prices being
5 reduced in Canada?

6 MR. THOMPSON: Yes, indeed it was.

7 MR. MACLEOD: And that was the first reduc-
8 tion was it not from the date of the introduction of
9 your brand of tetracycline?

10 MR. THOMPSON: I don't have the full price
11 history with me Mr. MacLeod so I am reluctant to make a
12 categorical statement that it was the first reduction.
13 It was the first reduction for several years.

14 MR. MACLEOD: Well I have some figures
15 furnished by your company which would appear to indicate
16 that the only price given is for the 16 size.

17 MR. THOMPSON: February 1954. Well then,
18 I am sure that is accurate. Thank you.

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CC/PB/hm

1 MR. MacLEOD: Isn't it a fact that in the
2 case of a company preparing a drug such as Aureomycin for
3 resale that the cost of the basic drug itself is a
4 relatively small factor?

5 MR. THOMPSON: I think we have furnished
6 evidence as to our own, in Cyanamid of Canada, through the
7 returns we have made to the Director to the effect Cyanamid
8 of Canada paid some \$340.00 a kilo for the 88% crude
9 aureomycin which is then refined and chemically converted
10 to Achromycin in Canada.

11 MR. MacLEOD: You drew a distinction in
12 your brief between the situation with respect to the older
13 penicillin and the broad spectrum antibiotics. The
14 Director had suggested that the ability of numerous firms
15 to enter the production and distribution of the older
16 penicillins had resulted in the prices being forced down
17 to the cost of production and in some cases below the
18 actual cost so that some companies lost money on them.
19 Now, there is no question, is there, of the price competi-
20 tion in the broad spectrum field forcing the price down to
21 the cost of production?

22 MR. THOMPSON: I don't think a pharmaceutical
23 company can operate and survive if it sells dosage form at
24 cost of production on the dosage form. Am I answering your
25 question, Mr. MacLeod?

26 MR. MacLEOD: I am just suggesting to you
27 the Director's distinction is valid, there is no parallel
28 situation here, that the situation with respect to the
29 penicillins, the older penicillins is entirely different
30 than the situation with respect to the broad spectrums?



1 MR. THOMPSON: I recognize two distinctions
2 between these two situations. Number one, penicillin when
3 it first came out on the market was made by an old and
4 now very obsolete surface fermentation method, where the
5 growth of the mold occurred on the surface of the liquid
6 and the capacity for growing the mold was determined by
7 the amount of surface area of the liquid that could be
8 made available. Now, it wasn't long after penicillin
9 was on the market -- I might add my own company made
10 penicillin by this method during the war and continued to
11 do so at the request of Government Authorities long after
12 the more efficient method had been developed. That more
13 efficient method is the deep fermentation where, instead
14 of being limited to the surface area of the fermenting
15 vessel, one has available the depth. It becomes not
16 surface, but volume. Lederle found itself in a very
17 definite competitive disadvantage from having continued
18 with the older method in order to guarantee a supply while
19 competitors converted, with an interruption of production,
20 to the deep fermentation method. This development had the
21 effect of sharply reducing the cost of producing penicillin,
22 and yet it was from this take-off point that our company
23 proceeded into the work of a broad spectrum antibiotic that
24 led to Aureomycin and the others, so that these were never
25 made by merely surface fermentation, but always by the deep
26 fermentation method. We traded on the experience in the
27 development of penicillin and used that as a starting point.

28 There is another distinction I would like
29 to draw, that is in the case of penicillins there developed
30 large over-capacity for production which meant a great deal



1 more penicillin could be produced than could be consumed.
2 The result was that there was, I would suggest an economic
3 waste, and that idle facilities had to be supported and
4 carried and at the same time there was competition which I
5 think Dr. Ferguson of the Connaught Laboratories described
6 more eloquently than I in his testimony before the Ontario
7 Select Committee. Many producers were forced out of
8 business and I think as has been indicated a good deal of
9 money was lost. I hope this won't happen with the broad
10 spectrum field. I think it is not in the public interest
11 to build facilities that cannot be used and support them
12 idly.

13 MR. MACLEOD: Isn't the reason that
14 situation developed with respect to penicillins and didn't
15 develop with respect to the broad spectrums, the fact the
16 broad spectrums are tightly controlled by patents? I am
17 not suggesting there is anything wrong. I am just asking
18 for your opinion as to whether that is not the reason.

19 MR. THOMPSON: Well, Mr. MacLeod, my answer
20 will have to be in the form of opinion. I don't think so
21 because broad spectrum antibiotics include not just the
22 tetracycline but chloramphenicol and this range must
23 compete with the other antibiotics which overlap into the
24 range of treatment with the tetracycline antibiotics. If
25 you look at the width of the spectrum for penicillins and
26 then superimpose on that the width of spectrum for
27 tetracyclines you will find a substantial area of overlap.
28 I think it is a very difficult decision for a practising
29 physician to make, whether to prescribe penicillin for an
30 ill patient in the belief that the organism probably falls



1 within the penicillin spectrum or whether to purchase
2 extra insurance for his patient by covering the broader
3 range by the use of some broad spectrum antibiotic. These
4 two different classes of antibiotics are constantly in
5 competition with one another and the physician's office,
6 I suggest, this is the point where the decision is made
7 on balance, whether to use the tetracycline for treatment
8 or a penicillin. I don't think it is fair to say that
9 the tetracyclines are closely controlled or restricted
10 because the manufacturers engaged in marketing these drugs
11 are not isolated in the antibiotic field. They need to
12 compete with all of the others.

13 MR. MacLEOD: It is a further fact there
14 wasn't a single price change in the price of broad spectrum
15 antibiotics for a period of approximately ten years in the
16 United States and about eight years in Canada.

17 MR. THOMPSON: From 1954 to 1960 -- I think
18 we mentioned in our return to the Director the introduction
19 date of Aureomycin was some time in 1954. Yes, that is
20 true. That was the period, Mr. MacLeod, of a fairly sharp
21 inflation, cost inflation during which there were two
22 forces at work. One was the upward pressure on all costs.
23 There was also a very strong competition struggle, very
24 active competition struggle to reach the market and de-
25 termine what would be the ultimate result of the tetra-
26 cycline preparation in the field of hemotherapy and the
27 cost of everything that went into this, promotional cost,
28 manufacturing cost, warehousing cost, everything was forced
29 upward by inflation. At the same time there was a general
30 expansion on the market with a corresponding advantage again



1 being in terms of increased volume. These forces were
2 both at work during that period, so I suggest, Mr. MacLeod,
3 that the significance of the static price situation that
4 you refer to would have to be considered in the light of
5 those two posing influences.

6 MR. MacLEOD: Over the same period the
7 price of penicillin was dropping steadily.

8 MR. THOMPSON: So that these two plants we
9 know of in Canada had shut down because they were such a
10 burden to their owners. They were better off to pay
11 depreciation than keep them running.

12 MR. MacLEOD: I want to touch a point you
13 mentioned a moment ago. You spoke about inflated costs.
14 Isn't it a fact that with a specialty which is patented,
15 which one company or a small group of companies completely
16 controls the major expenses are likely to be the research
17 to produce the drug and the promotion on the drug to
18 doctors? In other words, are you not faced with a terrific
19 initial outlay, with a drug such as tetracycline instead
20 of your costs increasing as you go along your cost should
21 be dropping because you are recovering a large part of your
22 prior expenditures.

2 23 MR. THOMPSON: Yes, again it is a very
24 difficult decision for a manufacturer to make in launching
25 a preparation such as Aureomycin as to what price should
26 be set. That is normally done at a time at which scale
27 production -- there is no appreciable scale of production
28 and it is exceedingly difficult to project what the trend
29 of cost will be as the volume arises. It is also virtually
30 impossible to predict the useful market-life of the product



1 and to predict over what period the capital cost of
2 developing the product should be recovered. You may well
3 find a competitor with a different view on the subject.

4 MR. MacLEOD: Is tetracycline still a large
5 selling drug?

6 MR. THOMPSON: Yes, it is an important one.
7 Declomycin has been gaining significantly, of course, at
8 the expense of tetracycline and tetracycline is declining.

9 MR. MacLEOD: Well tetracycline has had a
10 reasonably long life even up to this time.

11 MR. THOMPSON: Oh yes it has indeed. It is
12 very definitely being challenged. It has been since 1959.
13 We expect that the volume of tetracycline will continue
14 to decline as physicians come to prefer newer antibiotics
15 such as demethylchlortetracycline.

16 MR. MacLEOD: Chloramphenicol, of course,
17 is an example of a drug having a long useful life.

18 MR. THOMPSON: I would have to refer you
19 to Parke Davis who are the people who introduced that. My
20 understanding is, from sources I read, it has fallen
21 somewhat into disfavour due to side effects. I read this
22 recently in a medical journal.

23 MR. MacLEOD: Do you find chloramphenicol
24 and chloromycetin are much in competition with you?

25 MR. THOMPSON: Very definitely.

26 MR. MacLEOD: And have been for a period of
27 something like 12 or 13 years now?

28 MR. THOMPSON: Yes, it is becoming increasingly
29 so as its position saleswise on the market is becoming
30 established. When new products are introduced, Mr. MacLeod,



1 there is invariably a difference of opinion as to how
2 much should prevail among the companies sponsoring each
3 drug. This is always resolved in the marketplace by the
4 preference of the users. Sometimes it takes several years
5 for this sort of situation to stabilize.

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1 MR. MACLEOD: May we just jump back to
2 something I was looking at before, that is, the Kefauver
3 Report. If we assume that these figures are correct
4 figures of Bristol's, the total cost of \$5.03 for 100,
5 250-milligram capsules - 100 250-milligram capsules
6 would be 25 grams, would it not?

7 MR. THOMPSON: Could I ask you, Mr. MacLeod,
8 if you would just say that again?

9 MR. MACLEOD: 100 250-milligram capsules
10 would be equivalent to 25 grams, would it not?

11 MR. THOMPSON: Yes.

12 MR. MACLEOD: Which would be a fortieth of
13 a kilogram?

14 MR. THOMPSON: Yes.

15 MR. MACLEOD: So that on that basis, Bristol
16 in the United States, its total cost of preparing tetra-
17 cycline, doing all the operations necessary and bottling
18 it and labelling it so that it is ready for re-sale, is
19 only \$211.20 per kilogram.

20 MR. THOMPSON: That is based on taking the
21 \$5.03, is it, Mr. MacLeod?

22 MR. MACLEOD: Yes.

23 MR. THOMPSON: Accepting that figure?

24 MR. MACLEOD: Yes.

25 MR. THOMPSON: The total cost of preparing
26 it ready for re-sale would be \$211.20.

27 THE CHAIRMAN: Would that not be subject to
28 any wastage there is?

29 MR. THOMPSON: Pardon?

30 THE CHAIRMAN: Would there be any wastage?



1 MR. THOMPSON: It is very difficult for me
2 to say, Mr. Chairman, as we are referring to a competing
3 company.

4 THE CHAIRMAN: But you are familiar with
5 that kind of process. Do you normally expect some wastage
6 converting a kilogram of material into milligrams?

7 MR. THOMPSON: Yes, I see what you mean.

8 THE CHAIRMAN: Is there some loss?

9 MR. THOMPSON: Yes, there is always a loss.
10 For one thing, a surplus is frequently incorporated into
11 a capsule. There will always be some waste such as
12 sampling losses and so on, and the method of accounting
13 within the company can put these in different categories.

14 THE CHAIRMAN: But you might not get 4,000
15 tablets out of a kilogram.

16 MR. THOMPSON: Indeed you would not.

17 MR. MACLEOD: This purports to be the cost
18 of the finished product with wastage and everything else
19 allowed for. These are the tablets bottled, labelled,
20 sealed, ready for sale, and it seems to me that there is
21 something wrong somewhere when Bristol can produce this
22 product ready for re-sale to the public at a total cost of
23 \$211.20 in the United States and you buy the crude drug
24 before it is refined for something over \$300.

25 MR. THOMPSON: Well, Mr. MacLeod, the price
26 that we pay to our parent company, have been paying, is
27 more than just a basic cost for the bulk crude material.

28 MR. MACLEOD: Yes.

29 MR. THOMPSON: It includes - it is one of
30 the ways in which we contribute to the research programme



1 in our parent company. The methods by which this kind of
2 relationship takes form are changing in the industry and
3 we are perhaps a good example of that because we will
4 cease - we have already discontinued the importation of
5 materials which you have described and we will now produce
6 it in Canada. We also are now in the process and in fact
7 have been negotiating an agreement on research and develop-
8 ment, an agreement between Cyanamid of Canada and our
9 parent organization, so that there will be a separate fee
10 charged for research and development which in the past
11 has been transmitted to the parent company through the
12 medium of raw material purchased, not just tetracyclines,
13 but of other things.

14 MR. MACLEOD: Do you know if it is a fact
15 that Bristol pay American Cyanamid a royalty on the Aureo-
16 mycin that it uses to manufacture tetracycline?

17 MR. THOMPSON: That would be a very simple
18 thing to find out, Mr. MacLeod, but I don't know.

19 MR. MACLEOD: You don't?

20 MR. THOMPSON: No.

21 MR. MACLEOD: It is so stated in the anti-
22 biotics report, the economic report of the F.T.C. on
23 antibiotics. So that, if that is correct - and incidentally
24 it is also stated that Bristol pays Pfizer a royalty in
25 respect of the tetracycline which it sells - so that in
26 addition to the cost of manufacturing, it pays two outside
27 companies royalties, and it is still able to produce the
28 finished product capsuled and ready for re-sale at consi-
29 derably less than you can buy the crude.

30 MR. THOMPSON: It would be very interesting



1 to see what happens to our costs when we start manufac-
2 turing in Canada.

3 MR. MACLEOD: Mr. Thompson, I was confused
4 by certain of your statements this morning. You insist
5 that you think that there is price competition in the
6 sale of broad spectrum antibiotics.

7 MR. THOMPSON: I do believe that, Mr.
8 MacLeod.

9 MR. MACLEOD: Price competition in the
10 sense that prices are all the same but there is no price
11 competition in the sense that any producer cuts the price
12 in an attempt to get business.

13 MR. THOMPSON: This has happened twice in
14 the past year.

15 MR. MACLEOD: For the first time in a consi-
16 derable number of years.

17 MR. THOMPSON: Between 1954 and 1960, during
18 which period I think I indicated that at least in my
19 company there were two opposing forces at work, which
20 tended to maintain level pricing and encourage level
21 pricing.

22 MR. MACLEOD: I think you suggested, too,
23 that even the older penicillin was a competitor of the
24 broad spectrums.

25 MR. THOMPSON: Yes indeed.

26 MR. MACLEOD: But its price is far below
27 that of the broad spectrums.

28 MR. THOMPSON: Yes, and I think it may also
29 be said that in the case of many physicians, the broad
30 spectrum antibiotics that we are talking about are worth



1 the difference.

2 MR. MACLEOD: But the lower price of the
3 substitute product does not bring down the price of the
4 broad spectrums.

5 MR. THOMPSON: It has a very definite
6 influence, I think, on the price of the broad spectrums,
7 and I think there is a pattern in their relationship.
8 There are physicians who are using more penicillin and less
9 tetracycline now for this reason, due to the ---

2 10 MR. MACLEOD: Because of the price?

11 MR. THOMPSON: Pardon?

12 MR. MACLEOD: Because of the difference in
13 price?

14 MR. THOMPSON: Yes.

15 THE CHAIRMAN: You mean, Mr. Thompson, that
16 a number of physicians make the choice to use penicillin
17 which in their own opinion may not be as effective because
18 of the difference in price, they would prefer to prescribe
19 it for certain patients.

20 MR. THOMPSON: Yes to some extent. It is
21 a question of how ill the patient is and what is the
22 extent of the risk. If the patient is not seriously ill,
23 the physician may well start with penicillin knowing
24 there is a greater possibility with penicillin if the
25 patient has an infection, that penicillin would reach,
26 and also knowing that there is a risk of a penicillin
27 reaction in a small percentage of cases, and he may prefer
28 to take those risks knowing that the patient is not
29 seriously ill, but the choice is also there to switch to
30 a more costly and more potent drug at a later date.



1 MR. MACLEOD: In discussion of your brief,
2 some questions were asked in relation to cost in other
3 countries. Were the statements which you made and the
4 quotations in your brief to your knowledge based on any
5 specific study, or were they just matters of general
6 information?

7 MR. THOMPSON: The figures that were quoted
8 from my own company's products in other countries were,
9 of course, from sources within the company.

10 MR. MACLEOD: Yes.

11 MR. THOMPSON: I consulted the Managing
12 Director of our International company and sought his
13 assistance.

14 MR. MACLEOD: I was not speaking of that.
15 I was thinking of things such as labour cost and transpor-
16 tation cost and more or less general factors that are, if
17 not referred to by you specifically, are referred to by
18 persons whom you quote.

19 MR. THOMPSON: Oh yes. I think in several
20 cases I have quoted others.

21 MR. MACLEOD: But to your knowledge those
22 statements were not based on specific studies, were they?

23 MR. THOMPSON: Well, I think I made more
24 than one statement in that area, Mr. MacLeod. Perhaps
25 it would be more accurate to take them individually.
26 Which statement did you have in mind? Would you mind
27 telling me which statement you are referring to? On page
28 14 of my brief I quoted Mr. John T. Connor.

29 MR. MACLEOD: Yes.

30 MR. THOMPSON: Since he was testifying under



1 oath, I have quoted him without questioning the accuracy
2 of his sources. I don't know where his figures came from.

3 MR. MACLEOD: I don't want to dwell on that,
4 Mr. Thompson. I think, in connection with it, it might be
5 appropriate if I pointed out to the Commission that there
6 is a recent study which was only published last month by
7 the National Industrial Conference Board of the comparative
8 cost of doing business, that is manufacturing, in the
9 United States and in various foreign countries and the
10 Director has ordered a copy of that study and will make
11 it available to the Commission, and of course it will come
12 directly to bear on this particular point.

13 THE CHAIRMAN: Mr. MacLeod, just to get that
14 clear, that is manufacturing costs in general. It is not
15 just directed toward drugs.

16 MR. MACLEOD: No, it is in general.

17 MR. FRAWLEY: Was the studying body American
18 or Canadian?

19 MR. MACLEOD: It is by the National Industrial
20 Conference Board in the United States, and all the informa-
21 tion I have on it is an article in Business Week at page
22 111 of the September 23rd issue.

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MR. MacLEOD: I don't want to waste any time on this, but I will put before you a photostat of a letter by an official of Cyanamid of England which appeared in the "New Stateman". Would you just glance through it ?

MR. THOMPSON: Yes, Mr. MacLeod.

MR. MacLEOD: That letter was written as correspondence to the editor in connection with an article "Great Drug Racket", copy of which is also in that file, but I think an official of your company makes a point that costs of a subsidiary operation such as Cyanamid operates in England cannot be considered in isolation. I think he says there, a passage, "because there are a lot of English companies operating in Canada and the U.S. making high profits".

MR. HALL: Is that a long letter? Do you propose to read it into the record?

MR. MacLEOD: My point is quite a simple one. The paragraph to which I want to draw particular attention is this:

"Comparisons of profit to capital employed can be dangerously misleading. Comparatively, British firms operate lucratively in the United States with minimal capital investment. Their ratio of profit to capital employed may also be relatively high. Doctrinaire questions aside, does Mr. Parsons also disapprove of these activities?"

The simple point he makes is that you cannot look at Cyanamid's operations in England alone. On the face of it



1 they apparently make a very high profit, but that is
2 misleading.

3 MR. THOMPSON: I think that is probably
4 reasonable in connection with the British company.

5 MR. MacLEOD: Would you say the same situa-
6 tion would obtain in Canada?

7 MR. THOMPSON: No, I don't think it does
8 obtain in Canada.

9 MR. MacLEOD: Do you think that the
10 financial statement of the Canadian Cyanamid would accurately
11 reflect its true operations?

12 MR. THOMPSON: Well, Mr. MacLeod, there are
13 a couple of peculiarities in connection with Cyanamid of
14 Canada that I think I should point out to you.

15 MR. MacLEOD: Yes.

16 MR. THOMPSON: The first one is, and I will
17 answer your question by saying yes, I think the statement
18 does accurately reflect the operations of the company, but
19 if you are not already aware of it, and if the Director is
20 not already aware of it, I think it should be made clear
21 in Canadian sales volume approximately 10% is ethical
22 pharmaceuticals, and the remaining 90% is totally different
23 types of business.

24 MR. MacLEOD: Yes.

25 MR. THOMPSON: It is a consolidated state-
26 ment. Many of the services which the company utilizes in
27 Canada are common to all of the sales volume, and not just
28 to the pharmaceutical business, so that it becomes a matter
29 of opinion almost how the fixed costs shall be allocated,
30 and you can talk to six accountants and perhaps get six



1 different answers.

2 I do believe, however, that our Canadian
3 drug business stands honourably on its own feet, economically
4 and financially, and that it can be in that sense considered
5 as an entity.

6 MR. MacLEOD: Yes. Of course the Canadian
7 drug company on its own would never have developed tetra-
8 cycline.

9 MR. THOMPSON: No, I don't know. I am
10 confident -- perhaps I could just elaborate on that for
11 one moment. I believe in the future research in this
12 field will increasingly have to be a worldwide entity in
13 order to take advantage in the most efficient way of the
14 skills, specialized skills that are needed and are
15 available in different areas, and this is one of the
16 reasons why I referred to the establishment of a funda-
17 mental research laboratory in Switzerland, which is a
18 pure basic research laboratory, which I hope will help our
19 Canadian company. We are contributing to its cost, and
20 we expect results.

21 MR. MacLEOD: So that at least in respect
22 to your company you would not say that the statement by
23 your official to the effect that you cannot judge a branch
24 independently from its relationship with its parent does
25 not apply?

26 MR. THOMPSON: I think it is very probably
27 accurate as said by Pete Williams for the British company,
28 which is now functioning at Gosport, a fully integrated
29 antibiotic production unit. There is a difference in that
30 this is not yet true in Canada, and I don't think that it



1 is possible to take a statement made about the British
2 subsidiary, which, incidentally exports substantially to
3 other countries, and apply it to Canada which has two
4 differences; one is exporting opportunities are very
5 limited indeed. We simply can't compete in foreign markets
6 we find, and where the antibiotic production is on a
7 different basis.

8 MR. MacLEOD: The gist of his statement,
9 as I understood it, was that you could start a branch on
10 relatively limited capital when you have a head office
11 to rely on.

12 MR. THOMPSON: That is true of a branch,
13 yes.

14 MR. MacLEOD: And I wanted to ask you about
15 it because that is so true of the drug industry in Canada
16 that so many of the large firms in Canada are simply
17 branches of U.S.

18 MR. THOMPSON: I agree that has been the
19 pattern for this whole industry, but I believe that is
20 changing.

21 MR. MacLEOD: Yes?

22 MR. THOMPSON: An increasing number of
23 Canadian companies for example have their own presidents
24 and are managed by a board of directors which cuts the
25 strings very substantially from the close integration that
26 has been the pattern in the past.

27 I will go further, Mr. MacLeod, and hope
28 that my comment may assist you by saying that the profitability
29 of our Canadian drug business is well in line with averages
30 which have been published as a result of surveys, and that



1 this is true on any conceivable basis of accounting.

2 This is not the result of an unusual or
3 artificial relationship with our American company at all.
4 I cannot speak for my competitors, but that is true of
5 my company.

6 THE CHAIRMAN: Mr. MacLeod, would you be a
7 little while yet?

8 MR. MacLEOD: I won't be very long.

9 THE CHAIRMAN: It is half past three. If
10 you are just going to be a few minutes, we will complete
11 this.

12 MR. MacLEOD: Mr. Antoft in Montreal --
13 perhaps you were present when he gave evidence -- took some
14 exception to the classification of firms, general
15 classification made by the Director. Have you any opinion
16 on that? Have we misstated the position of the small firms?

17 MR. THOMPSON: I would have to refresh my
18 memory on the nature of the statement, Mr. MacLeod. I
19 certainly agree with Mr. Antoft that a small firm may well
20 be created, but I got the impression in reading the Green
21 Book, and possibly inaccurately, but it certainly impressed
22 me that the Director looked upon large companies as being
23 large simply because they are American.

24 Of course large companies are not all
25 American, and I feel strongly about this, that they are not
26 large because of any national or international connections.
27 They are large because they do a good job on the market;
28 because they render services that are needed and appreciated.

29 Many of the small companies are of necessity
30 in the classification of being imitators because they have



1 no research facilities, and I make an exception in the
2 case of Mr. Antoft. I think he has done an exceedingly
3 efficient job in his company from what his brief contained
4 in that regard, but generally speaking small companies are
5 unable to put forth the creative effort necessary to bring
6 new drugs into use.

7 If I may ramble just for a second, I was
8 personally involved in such a company. E. B. Shuttleworth
9 Chemical Company was established in Canada in 1879. It
10 was the first company so to be established. It operated
11 as an independent Canadian enterprise until early in 1957.
12 During that intermediate period of time it struggled, and
13 it gradually lost its position in the market. It was
14 limited to the manufacture of imitations of products
15 created by others, and it had an exceedingly difficult time.

16 My father was the principal owner of that
17 company, and I can well remember the economic hardships in
18 which I grew up in the 1930's.

19 Now, the company survived World War II, but
20 by now, by the end of World War II, was reduced to one of
21 what you would call these smaller companies, with a sales
22 volume of about \$400,000.00 a year I would say. The
23 company struggled on for more than ten years after the war
24 with decreasing profitability, and I returned to the
25 company in 1955, and I was struck immediately by the
26 incompetence of this enterprise to compete with the research-
27 oriented international companies with which I had had
28 experience, and I advocated reluctantly, but after much
29 thought, the sale of this business or in some other manner
30 its affiliation with a research-oriented company, and it



1 became a wholly-owned subsidiary of the Pitman-Moore
2 Company, and I became its president at that time.

3 I lived through several years of exceedingly
4 difficult competitive struggling to convert this company
5 from one with several hundred products all selling in small
6 sales volume to one with attractive and useful specialties
7 based on research, and I can assure you, Mr. MacLeod, that
8 the transformation was dramatic that took place in that
9 company. It became possible to finance a new plant. It
10 increased its employment, and increased its share of the
11 market. It increased its profitability, and, forgive me
12 for rambling, but I thought it might be a useful example.

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MR. MacLEOD: Yes. Well the main point

2 that the Director drew was "the principal characteristics
3 of the large firms are that they have facilities to
4 manufacture and prepare complicated drugs and dosage forms
5 of these drugs, that they carry on research, that they are
6 able to develop company specialties either by developing
7 new drugs or by developing combinations which have or are
8 claimed to have unique properties, and that they are able
9 to carry out promotional activities on a scale that ensures
10 that their products are known and recognized by the medical
11 and pharmacal profession." The Director also said that
12 in the case of the small drug houses this wasn't true.
13 While their products might be just as good they did not
14 deal "in the newer and more complex drugs (unless they
15 merely purchase such drugs for resale); they carry on
16 little or no research, they are not able to develop new
17 drugs or important specialties and they are unable to carry
18 on elaborate promotional campaigns."

19 MR. THOMPSON: I would disagree with the
20 Director only in regard to the question of promotion. I
21 don't believe that mere size limits ability of a company
22 to bring a good new drug into use. It will certainly take
23 longer but given the advantage of merit, in the technical
24 merit in the product and in the skillful management and
25 efficient use of the promotional funds that are available,
26 I firmly believe that a small company can establish a
27 place for itself and bring a drug into use to the scale
28 that it rightly deserves.

29 THE CHAIRMAN: On that point, Mr. Thompson,
30 isn't there a handicap the small company would have in that,



1 as we have been told, many of the new drugs have a fairly
2 limited period of wide use because of other drugs coming
3 on the market and supplanting them. The small company,
4 taking longer to get on the market, might find that the
5 market has disappeared before it had been able to take
6 real advantage of it.

7 MR. THOMPSON: That is true Mr. Chairman.
8 Not all drugs have so short a life in the marketplace and
9 we can cite an example of a small company which currently
10 occupies first place, according to surveys, independent
11 surveys in furnishing a pre-natal dietary supplement taken
12 as a protective measure for pregnant women and this has
13 been a long struggle by the company, in which I participated,
14 but a successful outcome over the period of time and I
15 think this is a useful contribution. It reduces the cost
16 of this type of treatment. I think it was quite a proper
17 outcome.

18 MR. MacLEOD: You mentioned this morning,
19 I think, that the drug industry was a very risky business.
20 Isn't it a rather notorious fact that firms do not drop out
21 of this business? They do not drop out of this industry?
22 Any firm, once started continue for years, and some of the
23 larger firms have been going for as long as a century?

24 MR. THOMPSON: Oh yes, but I do not see there
25 is an incompatibility in that situation Mr. MacLeod. The
26 risk that I referred to is the decisions that have to be
27 made when a new drug is available.

28 I can cite for you the example of a tran-
29 squilizer which my company is currently marketing. This is
30 a new drug still. It has only been on the market a matter



1 of a few weeks. I think it is virtually impossible to
2 forecast just where this drug will eventually take its
3 place in the pattern of tranquilizers.

4 For one thing, I have no way of knowing
5 how the broad community of physicians will judge my drug
6 in comparison with the many good tranquilizers on the
7 market. I have to guess, and I have to bet money on the
8 introduction of that drug on the basis of such a guess.

9 Now I might very well lose money for my
10 company by an unwise or inaccurate decision and it is this
11 risk to which I referred. I have the option of placing
12 my promotional dollars in other areas where I perhaps think
13 they would be more efficiently spent, and it is my duty
14 to see that they are used to the very best advantage in
15 the long range future of my company. These are constant
16 risks.

17 MR. MacLEOD: Nevertheless, despite what
18 you say is it not a fact that the rate of failure in the
19 drug field is very much lower than in most other fields?
20 Isn't that generally recognized?

21 MR. THOMPSON: Well Mr. MacLeod perhaps the
22 take-over of a Canadian, a small Canadian struggling
23 Canadian company by a larger international organization
24 could be classed as a failure because the alternative surely
25 would be failure and to that extent I am afraid I can't
26 agree with you.

27 MR. MacLEOD: I think that statement is
28 regularly made by writers in this field and it certainly
29 appears in some of the articles that are referred to.

30 MR. THOMPSON: I question whether a similar



1 statement would be made by people of experience in the
2 field.

3 MR. MacLEOD: There was one small point I
4 wanted to clear up. You said this morning that, taking
5 Tetracycline as an example, that there would be differences
6 in the products of various manufacturers. That is one
7 might use a different type of capsule or different
8 excipients, something of that nature?

9 MR. THOMPSON: Yes, there is no standard
10 that requires identity in formulation. That is correct.

11 MR. MacLEOD: In practice does this lead
12 to a doctor using, for example, your brand of Tetracycline
13 in one instance and say Squibb's brand for instance in
14 another or does the doctor normally when he wants Tetra-
15 cycline use one brand?

16 MR. THOMPSON: It is rather an interesting
17 comparison that you have picked because according to the
18 information I have the Squibb Company markets Tetracycline
19 only in combination with an agent calculated to reduce the
20 incidence of overgrowing fungus infection that develops.

21 MR. MacLEOD: Let's take Pfizer. Take
22 Pfizer.

23 MR. THOMPSON: There is a strong brand
24 loyalty. At least we have experienced that in our own
25 company. We have found that physicians who have used
26 Achromycin are very well satisfied and tend to continue to
27 use it. It's a little difficult for me to speak of a
28 competitor, but I can say that the physician who is using
29 my product is visited regularly by Pfizer people who
30 always have good reasons why he should change away from my



1 product to Pfizer's.

2 MR. MacLEOD: But you find that there is
3 a certain amount of brand loyalty?

4 MR. THOMPSON: Yes, and I contribute it to
5 some degree at least to the reputation that we have sought
6 to build for our company. We would like physicians to have
7 confidence in a product simply because it comes from our
8 company. That is one of our objectives; the way we conduct
9 ourselves.

10 MR. MacLEOD: The point I wanted to clear
11 up, I was quite sure of it in my own mind but I wanted to
12 get it on the record that when you spoke about the
13 difference you didn't mean that in practice the doctor
14 uses your drug today and somebody else's product tomorrow?

15 MR. THOMPSON: No, I didn't mean that. I
16 beg your pardon, in the case of Tetracycline capsules I
17 think the physician requires experience with a particular
18 make of Tetracycline, particular brand, and he becomes
19 accustomed to the pattern of response and then his inclina-
20 tion is to continue to use it simply because it is a
21 familiar pattern to him. There is a reluctance to switch
22 because of the possibility that he may have to become
23 accustomed to a different pattern.

24 MR. MacLEOD: Has your company, to your
25 knowledge, ever tried to get a compulsory licence under
26 any patent in Canada?

27 MR. THOMPSON: Not to my knowledge Mr.
28 MacLeod.

29 MR. MacLEOD: To your knowledge has your
30 company refused to licence any other company which has



1 applied to it for a licence?

2 MR. THOMPSON: My company in Canada does
3 not hold the patents. My company is a licensee of the
4 American Cyanamid Company so we would have to refer that
5 question to them.

6 MR. MacLEOD: Any transaction of that
7 nature would take place with American Cyanamid?

8 MR. THOMPSON: Yes, and they would normally
9 be guided by conferences with us. I have not been involved
10 in any such situations.

11 MR. MacLEOD: You mentioned a specific
12 instance of buying a certain drug from Holland and Denmark.

13 MR. THOMPSON: I think it is in my brief,
14 sulfamethazine.

15 MR. MacLEOD: Do you buy other drugs from
16 Europe?

17 MR. THOMPSON: Oh indeed, yes.

18 MR. MacLEOD: Do you find that the quality
19 of such drugs is good?

20 MR. THOMPSON: Depends on where we buy
21 them Mr. MacLeod.

22 MR. MacLEOD: Perhaps you could give us a
23 little more detail on that.

24 MR. THOMPSON: Well when we are embarking
25 on the manufacture of a Lederle product in Canada, we first
26 make a detailed study of the technology involved. We
27 usually send people to our central research laboratory
28 to learn what precautions are necessary and what criteria
29 must be established on the raw material. By way of an
30 example, we mentioned Temposil several times this morning.



1 There was a great danger that the raw material of Temposil
2 may be contaminated by cyanides which are by-products of
3 the process that produces the drug.

4 Now in a situation like that we would take
5 elaborate precautions to eliminate cyanides and to
6 guarantee that they are eliminated so that the specifica-
7 tion would be strongly oriented to that objective and so
8 it is with other raw materials. Each has its own set of
9 standards appropriate to the purpose and to the origin,
10 to the circumstances in which the drug originates. Once
11 these standards become firm we prepare a specification and
12 we seek to produce our raw materials within the framework
13 of that specification. There are many such preparations.

14 For example, Lactose, a sugar derived from
15 milk is a basic ingredient in many dry pharmaceutical
16 preparations. We buy that where we best can within the
17 limitations of our specification for Lactose. We are
18 not interested in the merit of origin so much as we are
19 in whether or not the raw material meets our requirements
20 and whether it is available at the best price.

21 MR. MacLEOD: In your experience you can
22 buy perfectly satisfactory drugs in Europe?

23 MR. THOMPSON: Yes, indeed. There are some
24 excellent sources of pharmaceutical chemicals in Europe.
25 Ciba, Hoffman-La Roche are heavily engaged in this business
26 in Europe. British Drug Houses, Imperial Chemicals in
27 England, the many Fine Chemical Companies in Germany.

28 MR. MacLEOD: So that the use of the term
29 "foreign" as a term of opprobrium is not quite correct, as
30 you occasionally see drugs criticized because of their



1 foreign --

2 MR. THOMPSON: Certainly not. This would
3 be a criticism of British and American drugs also as you
4 read, and I think that would be most unfair.

5 MR. MacLEOD: Is there any pattern to prices
6 in this way, assuming a particular drug is available from
7 the United States and is also available from Europe, are
8 European prices usually lower?

9 MR. THOMPSON: I think it is very difficult
10 to generalize Mr. MacLeod because it depends to some extent
11 on how the drug comes into existence.

12 If it is primarily the result of a capital
13 investment operated by automatic or semi-automatic controls,
14 generally speaking there will be very little difference
15 in cost. If a great deal of hand labour is involved, it is
16 very likely that it will cost less in Europe.

17 MR. MacLEOD: But you think it would be
18 dangerous to make a general statement?

19 MR. THOMPSON: Yes, indeed I do. I can cite
20 two examples that I think illustrate the point. One is
21 the fermentation of an antibiotic in a large tank with
22 automatic controls which had been adjusted and preset to
23 maintain the control of that process. In a situation like
24 that one individual can supervise a very large amount of
25 fermentation.

26 In the case of the manufacture of surgical
27 sutures, which my company is engaged in, there appears no
28 satisfactory solution to the automation generally of this
29 process. A great deal of hand labour is required and it
30 is very difficult indeed to maintain good cost control in
the United States for these reasons, or Canada.



1 MR. MACLEOD: I think those are all the
2 points I want to cover.

3 MR. FRAWLEY: I was asking the witness some
4 questions about some figures and you may recall I didn't
5 have the paragraph in front of me. Certainly in fairness
6 to the witness and myself and to the record I think I
7 should now read the paragraph. It is a paragraph from the
8 Changing Times, the Kiplinger Magazine of August, 1960:

9 "In addition to cries of being smeared
10 for the 'guilt of success', the drug
11 industry presents figures to show that,
12 as a percentage of the consumer's dollar,
13 profits to the manufacturer are not so
14 handsome.

15 Dr. Paul C. Olsen, a professor at Brooklyn
16 College of Pharmacy and marketing research
17 director for Drug Topics and Drug Trade
18 News, figures the division of the pres-
19 cription dollar this way: 38% for actual
20 cost of production, another 38% for getting
21 drugs from factory to consumer and 12% for
22 taxes, with 12% remaining as net profit to
23 be divided between manufacturer, wholesaler
24 and retailer".

25 In view of my complete frustration in not
26 having your breakdown that I sought so diligently but
27 unsuccessfully for, I have to give you these figures.
28 Would you say these figures are correct figures to use in
29 looking at the prescription dollar in Canada?

30 MR. THOMPSON: I don't think I could go



1 beyond saying they are probably Dr. Olsen's information of
2 the breakdown in the United States. I am aware that is
3 a frustrating answer to you. I don't have figures to
4 indicate the breakdown on that basis in Canada and I
5 could only say whatever it is in Canada it is the result
6 of a long pattern of competition between companies. I
7 would like to say further that if my company could find a
8 way to reduce promotional content I would consider that
9 we had a great advantage over our competition and would
10 seek to use that immediately. In the absence of establi-
11 shing an individual opportunity for Cyanamid we have
12 recommended to the Commission the possibility of a co-opera-
13 tive device that might apply a downward pressure on these
14 elements of drug costs, so, Mr. Frawley, I simply can't
15 say that would be reasonable for Canada. No, I don't know.

16 MR. FRAWLEY: I put it to you this way; Dr.
17 Olsen says that 38% of the prescription dollar is used
18 for getting the drugs from the factory to the consumer.
19 In the case of Lederle is it 38% or more or less?

20 MR. THOMPSON: It is not 38%, Mr. Frawley.

21 MR. FRAWLEY: You say it is not 38%?

22 MR. THOMPSON: No.

23 MR. FRAWLEY: Mr. Thompson, if you are
24 willing to give that admission, which is the very first
25 one you have made in this little contest, why don't you
26 go the whole way and let us know what it is up to 100%?

27 MR. THOMPSON: I didn't make an admission.
28 I thought I stated a fact. You asked me if the cost of
29 getting the product from the shelf to the consumer ---

30 MR. FRAWLEY: From the factory to the



1 consumer.

2 MR. THOMPSON: From the factory to the
3 consumer was 38% for Lederle. I said, no. That is not
4 an admission of anything. That is a statement which I
5 believe was absolutely accurate. I didn't give you the
6 detailed breakdown. I think I gave you my reasons, Mr.
7 Frawley, and they haven't changed since this morning.

8 MR. FRAWLEY: We must not get into a discus-
9 sion of semantics. You are saying it is less than 38%.

10 MR. THOMPSON: No, Mr. Frawley.

11 MR. WAHN: He didn't.

12 MR. FRAWLEY: You said it was less than 38%.

13 MR. THOMPSON: No, I didn't.

14 MR. FRAWLEY: Perhaps I simply didn't hear
15 you correctly.

16 MR. WAHN: He said it wasn't 38%.

17 MR. THOMPSON: You said is the cost for
18 Lederle 38%? My answer was, no.

19 MR. FRAWLEY: It may be more than 38.

20 MR. THOMPSON: It may be more. It could be
21 less. I am sorry I can't say more.

22 MR. FRAWLEY: That leaves us where we were
23 this morning.

24 THE CHAIRMAN: Thank you, Mr. Thompson. I
25 think that will conclude the examination unless there is
26 something you wish to say yourself.

27 MR. THOMPSON: Mr. Chairman, there is one
28 thing: I know it is an imposition on the time of the
29 Commission. The expenditures of money on marketing of
30 pharmaceutical products is made in the case of my company



1 just as reluctantly as it is by Mr. Antoft. Could we
2 find a way to maintain a creative contribution in this
3 field without spending this money I would like to assure
4 the Commission we would have done so long ago. It seems
5 to me a fundamental issue is emerging and it is based on
6 the comparison, on the procurement of prices by public
7 agencies on the basis of competitive bidding which is a
8 worthy way to buy. It however has the effect of necessi-
9 tating that companies like mine must compete on the basis
10 of price along with companies who prefer not to engage in
11 the creative activities of research and the marketing of
12 new drugs. There is nothing to prevent the extension of
13 this philosophy to the point where it will be impossible
14 to remain in business and remain creative. My company
15 would be in just as good a position as any other to
16 compete in such a world. I suggest, though, if this
17 happened we would be in the position of having to depend
18 on some other agency to perform this work and that, as I
19 said this morning, development in the industry would come
20 to a screeching halt and we would have vigorous price
21 competition on the existing goods, but unless a new means
22 were found to create new ones, none would come forth.
23 Lederle would be forced to discontinue the research expen-
24 ditures which were quoted to the Director, quoted by the
25 Director in the 12 to 14-million dollar range from which
26 we hope to bring forth significant new entities, entities
27 which will materially reduce the cost of operating hospi-
28 tals, permit the treatment of patients in their homes and
29 which, I think, would be very worthy contributions. I
30 believe this kind of creativity occurs best in the



1 competitive climate. I believe that commercial research
2 has done well, that this is an economically sound proposi-
3 tion, and I fondly hope your recommendations will be so
4 formulated as to encourage its continuance. I think, Mr.
5 Chairman, that is all I can say.

6 MR. FRAWLEY: Mr. Chairman, Mr. MacLeod
7 expressed his own appreciation for Mr. Thompson appearing
8 here on behalf of Cyanamid of Canada. As the only counsel
9 who has undertaken his own questioning on behalf of the
10 public, any extended questioning, in any event, I
11 certainly want to associate myself with what Mr. MacLeod
12 said. It certainly has been a pleasure to me to be able
13 to talk to one manufacturer, to discuss with him frankly
14 and rather completely the prices of his products. Perhaps
15 the value and the meaning of my remarks will be a little
16 more meaningful after Mr. Hume's client has been before
17 us.

18 MR. THOMPSON: Thank you, Mr. Frawley.

19 THE CHAIRMAN: Thank you, Mr. Thompson. I
20 am sure the Commission is very appreciative indeed of the
21 mere fact you have taken the time and trouble to come here
22 and have prepared a complete brief and that you have
23 presented it in a very frank fashion. Thank you very much.

24 We will have a short break and then have the
25 Canadian Association of Consumers.

26
27 --- Short Recess
28
29
30



JW/dpw

1 MR. MACLEOD: Mr. Chairman, before you start,
2 it has been pointed out to me I inadvertently used a
3 figure of \$211.20 in respect of some comments I was making
4 earlier, and the correct figure is \$201.20.

5 THE CHAIRMAN: It is a little stronger than
6 it was before.

7 MR. MACLEOD: Yes. My multiplication was
8 not as good as it should have been.

9 THE CHAIRMAN: That is the kind of an error
10 you will be able to admit to.

11 MR. MACLEOD: Yes.

12 THE CHAIRMAN: We will resume the hearing
13 with a brief presented by the Ontario Branch of the
14 Canadian Association of Consumers, I believe presented by
15 Mrs. Underhill.

16 MRS. F.E. UNDERHILL, called

17 MRS. UNDERHILL: Gentlemen, this is a brief
18 of the Canadian Association of Consumers and is presented
19 by myself as Chairman of Legislation in the absence of
20 the President and also the Vice-President.

21 The Canadian Association of Consumers is, as
22 our name would indicate, an Association of Consumers
23 organized on a national, provincial and local basis to
24 study consumer problems, make recommendations for their
25 solution and to bring the views of the consumer to the
26 attention of our Government. The Canadian Association of
27 Consumers has been made aware and recognizes that public
28 opinion in this province is definitely in favour of the
29 lowering of the excessive price that the consumer is
30 charged for the use of medical drugs.



1 At the outset the Ontario Branch of the
2 Canadian Association of Consumers wishes to make it very
3 clear that it gives complete support to and is in complete
4 agreement with the brief presented to the Commission on
5 March 4, 1961, by Mrs. A.F.W. Plumptre, National President
6 of the Canadian Association of Consumers.

7 The consumer is in a different position
8 towards the purchase of drugs than he is to the purchase
9 of any other product. The reason for this is that the
10 purchase of drugs must be detailed, either by the patient
11 himself when he purchases a patent drug, or by the Doctor
12 when he prescribes a drug for the patient - to each indivi-
13 dual consumer. He is accordingly a captive buyer - with
14 little or no knowledge of the drugs ordered or the cost of
15 those drugs and frequently he does not have time or oppor-
16 tunity to shop around for the best value or price. As a
17 result, the consumer needs special protection, both as to
18 quality and to price of the drugs which he has purchased.

19 Competition is always essential to growth of
20 any product and also to the lowering of its price. It
21 would appear to us that there would seem to be virtual
22 elimination of price competition in both the manufacturing
23 and retail section of the drug industry.

24 Canada depends for most of her supplies of
25 basic drugs on import, chiefly from the United States.
26 Accordingly, as drug manufacturers patent many of their
27 products in the United States they have a legal monopoly
28 on the sale of these drugs. Since there is no provision
29 in that country for the issuing of compulsory licences,
30 manufacturers can and do charge what the traffic will bear



1 for their products. These manufacturers also take out
2 Canadian patents for their products and through their
3 Canadian subsidiaries dominate this market following the
4 same pricing policy. It is our understanding that the
5 provision in Canadian legislation for the issuing of com-
6 pulsory licences was designated to prevent the development
7 of monopolistic situations and it would appear to us that
8 the provisions of the Patent Act relating to compulsory
9 licences has not always been effective. Few compulsory
10 licences have been issued and it seems doubtful that
11 patent holders have issued many voluntary licences. The
12 result of this legislation is that manufacturers have
13 complete monopoly of the sale of their patented products
14 and as in the United States are charging exorbitant
15 prices.

16 While competition should act in such a way
17 that the cost of the products is brought down - it would
18 appear a possibility that the prices of similar type
19 products made by "name brand" drugs have not done so
20 without cost - for research costs money - that same
21 company stands to make a handsome profit should their
22 research be successful. Accordingly, while it has been
23 argued by some that the cost of research should be added
24 to the cost of the product - the company would tend to
25 disregard profit made by the fruits of their research.

26 The Canadian Association of Consumers is
27 satisfied and pleased that all drugs sold on the Canadian
28 market must meet the standards established by the Food
29 and Drug Directorate and that drugs not meeting these
30 standards are not permitted by the Food and Drug Directorate



1 to enter our market. Moreover, since the cost of drugs
2 sold under a name designated by a pharmaceutical house is
3 higher than the cost of a drug sold under its generic name
4 and since its quality is assured by the dictates of the
5 Food and Drug Directorate - the Canadian Association of
6 Consumers are of the opinion that drugs should be sold
7 under their generic name wherever possible. It makes no
8 difference to the consumer where the drugs are manufactured
9 as the quality of that drug is assured by our legislation.
10 Therefore, if a drug can be imported and sold at a lower
11 price to the consumer - its importation should be encour-
12 aged.

13 Since the Canadian Association of Consumers
14 is concerned not only with the cost of drugs but also with
15 the cost of living - the following recommendations are
16 made.

17 1. The Federal Sales Tax should be removed
18 from the sale of ethical drugs and drugs
19 which are of prime importance to the
20 consumer.

21 2. Since monopolistic control of the drug
22 industry is not desirable - the compulsory
23 licencing provision should be widened. We
24 recommend that as research relating to food
25 and drugs develops new formulae, compulsory
26 licences of right to manufacture, to import
27 and to sell be made available immediately a
28 patent has been issued.

29 3. We recommend the staff of the Food and
30 Drug Directorate be increased to ensure



1 continuation of its high standard of
2 quality control for drugs. This recommenda-
3 tion is made necessary by the former recom-
4 mendation.

5 THE CHAIRMAN: Mrs. Underhill, would you
6 mind if I just interject at that point? While we have
7 legislation, the Food and Drug branch Directorate is not
8 in a position, staff-wise, to assure the Canadian public
9 that all drugs manufactured or imported do in fact
10 comply.

11 MRS. UNDERHILL: Thank you very much sir.

12 THE CHAIRMAN: They simply are not in a
13 position to give that definite assurance, that all drugs
14 on the market are of good quality.

15 MRS. UNDERHILL: Thank you. I have requi-
16 sitioned that, sir.

17 4. We recommend that the wider use of
18 generic names of drugs be facilitated and
19 encouraged.

20 In conclusion the Ontario Branch of the
21 Canadian Association of Consumers is of the opinion that
22 if the sales tax were taken off ethical drugs, if monopo-
23 listic control of the manufacture and retail sale of drugs
24 was lessened and competition encouraged, and if our physi-
25 cians would prescribe by generic name wherever possible -
26 the consumer would receive not only a quality product but
27 better value for his dollar.

28 All of which is respectfully submitted.

29 Thank you sir.

30 MR. FRAWLEY: Mrs. Underhill, the Chairman



1 has pointed out to you that at the moment under existing
2 legislation, the Director under the Food and Drug admini-
3 stration has no staff nor does he make any attempt to
4 approve the quality of drugs.

5 Would you agree with me, Mrs. Underhill,
6 that it is just as important that the quality of our drugs
7 should be improved as the quality of a side of beef or a
8 tin of Niagara peaches?

9 MRS. UNDERHILL: Yes sir. Any time the life
10 of a person is at stake there should be a control on what
11 that person will consume, on the standard set.

12 MR. FRAWLEY: Do I understand from what you
13 have said at the conclusion of your brief that you would
14 favour such legislation and such new practices developed,
15 that the Director of the Food and Drug administration
16 would go further than he now goes, which is only to assure
17 the public with regard to the safety of the drug, not as
18 to its quality or its potency or its properties, and that
19 the approval of the Director should go further so that the
20 public would feel it could buy brand name drugs with
21 perfect assurance as to their quality.

22 MRS. UNDERHILL: I am of the opinion, sir,
23 that any drugs either imported or for sale to the general
24 public should have certain standards as set down, standards
25 of safety as required by the Government.

26 MR. FRAWLEY: When you say "safety" I put
27 it to you that they also are entitled to an approval as to
28 the standard of quality.

29 MRS. UNDERHILL: Yes.

30 MR. FRAWLEY: Thank you very much.



1 THE CHAIRMAN: Quality, potency, uniformity,
2 all of that?

3 MRS. UNDERHILL: Yes sir.

4 THE CHAIRMAN: I notice your second recommen-
5 dation, Mrs. Underhill, is that compulsory licencing
6 should be made available immediately a patent has been
7 issued. There would be no period at all of operation?

8 MRS. UNDERHILL: Sir, that is idealistic.
9 There is no doubt that when a patent is issued, most
10 assuredly it has to be tried, but we can depend upon
11 business not to bet on a loser, and accordingly after a
12 patent is issued, you will not find many other drug
13 houses taking it up promptly. They will wait and see
14 what the reaction is and then apply. So that I think
15 that common business sense dictates there.

16 THE CHAIRMAN: You think there would be a
17 period of greater or less duration in any event?

18 MRS. UNDERHILL: Yes sir.

19 THE CHAIRMAN: Even if the compulsory
20 licence is made available immediately, it would not be
21 made available.

22 MRS. UNDERHILL: That is right.

23 THE CHAIRMAN: Are there any other questions?

24 MR. MACLEOD: No sir.

25 MRS. UNDERHILL: Possibly there is one
26 point I would like to make at this time, and I am possibly
27 prompted to make it from the remarks of Mr. Thompson.

28 If a firm does research - and who doesn't
29 do research - Office Specialty do research on what type
30 of desk they are going to sell because they are included



1 in their market - they may be doing research for which
2 the health of the public will benefit, but on the other
3 hand, they would not do research if they themselves did
4 not gain. You can well be assured, because it is a
5 competitive world in which we live, that those same firms
6 would keep on doing research because they want to widen
7 their own market. That has been good business practice.

8 THE CHAIRMAN: You are disagreeing a little
9 bit with the last remark of Mr. Thompson.

10 MRS. UNDERHILL: I am indeed, sir.

11 THE CHAIRMAN: His argument was, I think,
12 along those lines although he did not refer specifically
13 at that time to patents, but I think he had that in mind,
14 that unless they have some assurance that if they spent a
15 great deal of money on research they would have a reasonable
16 opportunity of getting back their investment through the
17 sale of the product, they might not engage in research.
18 Your view is there would be still be enough room for profit
19 and they would engage in research anyway.

20 MRS. UNDERHILL: Yes, because competition
21 would make it so.

22 THE CHAIRMAN: That is an argument which we
23 have not had Mr. Thompson's answer on.

24 MRS. UNDERHILL: Thank you very much, gentle-
25 men. I would like at this point to tell you that the
26 Canadian Association of Consumers in future will be the
27 Consumers' Association of Canada, and we know in all your
28 deliberations you will consider yourselves not only as a
29 Government Board, but as heads of a home, as a consumer.
30 Thank you.



1 THE CHAIRMAN: We are all consumers, that
2 is right. Thank you very much.

3 We will adjourn until 10 o'clock tomorrow
4 morning.

5
6 --- Whereupon the hearing adjourned until 10 a.m.,
7 Wednesday, October 18th, 1961.

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INQUIRY UNDER SECTION 42
OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale
of drugs

By Director of Investigation and Research
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C.	--	Chairman
A.S. WHITELEY, M.A.		Member of the Commission
PIERRE CARIGNAN, Q.C.		Member of the Commission
F.N. MACLEOD		Combines Officer, representing the Director of Investigation and Research

Proceedings of hearings commencing at
10.10 a.m., Wednesday, October 18th, 1961,
et seq in the City of Toronto, in the
Province of Ontario.



Toronto, Ontario,
October 18th, 1961.

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--- On commencing at 10.10 a.m.

THE CHAIRMAN: We are having the presentation from the Hospital Association this morning. Mr. McCracken?

MR. MCCrackEN: Thank you, Mr. Chairman. Before I begin the brief, Mr. Chairman, do you have copies of it there? That is it with the pink cover. There are some additional copies here if anyone would like one.

I would like to tell you first, Mr. Chairman, something about the Canadian Hospital Association and our purpose of presenting this brief. First of all, the Canadian Hospital Association is a combination of all of the Provincial Hospital Associations and the Catholic Hospital Conferences in Canada. In addition, we have a number of associate members, which include various voluntary non-profit organizations in the health field, and Government Departments interested in the operation of hospitals or in public health and welfare.

Our services are available to organizations, hospitals, and individuals, and we maintain a close liaison with Federal and with Provincial Governments. In effect, therefore, we represent almost all of the voluntary hospitals through their respective hospital associations and conferences.

THE CHAIRMAN: I was not quite sure just how wide your representation is. Is it all the voluntary hospitals?

MR. MCCrackEN: Yes, sir.

THE CHAIRMAN: That includes municipal hospitals?



1 MR. McCracken: Yes, sir.

2 THE CHAIRMAN: And any Provincial?

3 MR. McCracken: No, it does not include the
4 Government hospitals; that is, Provincial Government and
5 Federal Government, nor does it include the private hospi-
6 tals.

7 The introduction to the brief is this: Mr.
8 Chairman and Members of the Commission:

9 The general hospitals of Canada, represented
10 by the Canadian Hospital Association, welcome the oppor-
11 tunity to present this information relative to the problem
12 of the manufacture, sale and distribution of drugs in
13 Canada, as they pertain to hospitals.

14 Since as hospitals, we are charged with the
15 responsibility of providing the best patient care at the
16 lowest possible cost, we are in favour of any action that
17 will help to achieve this objective. We submit this
18 presentation in the hope that the information contained
19 therein will assist the Commission in their consideration
20 of this matter.

21 To give some background information, we
22 start with functions of the hospital.

23 The Hospital's Role

24 The role of the community's hospital today
25 embodies a four-fold function:

26 (a) Patient Care - the continual develop-
27 ment of a high standard of patient care
28 leading to better health and longer life
29 for the citizens of the community it serves.

30 (b) Education - providing, in varying



degrees and depending on its size, a means for the education of doctors, nurses and skilled professionals whose specialized knowledge is essential to the practice of modern medicine.

(c) Research - again, in varying degrees and depending on size, participating in programs of research for new and improved techniques and treatments.

(d) Preventive Medicine - providing encouragement and support to the medical profession in developing programs designed to keep people well.

THE GOVERNING BOARD

The governing board is the supreme authority in the hospital. It has the responsibility to ensure that the hospital renders adequate services to the sick and injured at as low a cost as is consistent with efficiency. For example, we are quoting here from the Public Hospitals Act of Ontario, which reads in part as follows:

"...a hospital shall be governed and regulated by the board elected or appointed in accordance with the provisions of authority whereby the hospital is created, established or incorporated".

and

Regulation 3 states:

"...the board shall be responsible for the enforcement of the Act, these



1 regulations and by-laws of the hospital".

2 THE MEDICAL STAFF

3 Regulation 6 (1) (a) (iii) under the Public
4 Hospitals' Act of Ontario, states, in part, that:

5 ...the board shall provide for the
6 appointment and functioning of a
7 medical staff.

8 Now, we used the Public Hospitals' Act of
9 only one province because in our provinces they are
10 approximately the same.

11 The fact that a hospital board has this
12 legal obligation and right to appoint the individual
13 members of the medical staff is important in understanding
14 the hospital-physician relationship. While it is recog-
15 nized that a licence to practice medicine entitles a
16 doctor to practice his profession, it does not give him
17 the privilege of using the facilities and equipment of a
18 hospital without first having satisfied the requirements
19 of obtaining medical staff membership. However, in fulfil-
20 ling its responsibility in this respect, the board will
21 ordinarily have the advice and recommendations of the
22 existing medical staff.

23 It is essential to note that, as a guiding
24 principle in the medical staff organization of the hospi-
25 tal, the medical staff is self-governing in professional
26 matters. That is to say that while they are responsible
27 in the final analysis to the hospital board they alone
28 have the clinical knowledge to assess medical needs and
29 prescribe treatment. They are subject to the Public
30 Hospitals' Acts, the regulations thereunder, and the



1 by-laws within which their medical staff category functions,
2 but they still enjoy a reasonable degree of autonomy in
3 the treatment of their patients. For this reason, there-
4 fore, the hospital does not have control over the type and
5 quantity of drugs prescribed. This is the responsibility
6 of the physician while it is the hospital's responsibility
7 to make drugs available for the physician's use.

8 HOSPITAL FINANCING

9 Since January 1, 1961, with the inclusion of
10 the Province of Quebec under the Plan, hospital operating
11 costs are reimbursed to the hospitals by various provin-
12 cial boards and commissions for all insured in-patients.
13 This has virtually eliminated the large hospital deficits
14 which were fairly common prior to the introduction of the
15 Plan.

16 Hospital Insurance and Diagnostic Services Act of 1957

17 Under the financial formula, the federal
18 government contributes about one-half of the aggregate
19 sharable costs of the hospital insurance plans. In the
20 individual provinces, however, the federal share varies
21 since each participating province receives twenty-five per
22 cent of the national per capita cost of hospital services
23 plus, twenty-five per cent of its own provincial per
24 capita costs, multiplied by the population covered.

25 The Act enumerates the basic range of ser-
26 vices mandatory for any provincial scheme receiving
27 federal support. Each participating province is required
28 to make specified benefits universally available to its
29 population. The total days of care provided may not be
30 limited and must include basic public ward and other



1 in-patient service normally associated with the operation
2 of a hospital, together with certain diagnostic aids for
3 in-patients and, on a permissive basis, for out-patients.
4 Services may be provided in chronic as well as active
5 treatment hospitals, but legislation specifically excludes
6 care in tuberculosis sanatoria, mental hospitals and
7 institutions for custodial care. Capital costs are also
8 specifically excluded from sharable costs. Thus, the
9 federal act is set up to assist in provision of an insu-
10 rance system for basic general hospital services available
11 under uniform terms and conditions to the entire provin-
12 cial population. (Canada Year Book (1960), Page 272)

13 In 1958, (the latest figures officially
14 available) the total operating costs of our public general
15 hospitals was in excess of \$416,026,000. The breakdown
16 of these costs would be approximately: (Canada Year Book
17 (1960), Page 305)

	<u>Amount</u>	<u>Percentage</u>
18 Salaries and Wages	\$ 264,469,000	64%
19 Other	<u>151,557,000</u>	<u>36%</u>
20 Total	\$ <u>416,026,000</u>	<u>100%</u>

21 THE HOSPITAL PHARMACY

22 The hospital pharmacy provides one of the
23 fundamental services involved in the care of the patient
24 and it is increasing in importance each day as medical
25 research continues to add new pharmaceutical products and
26 new techniques for the doctor's use. During the last
27 thirty years new discoveries and advances in the method
28 of application of medication have included the development
29 of parenteral solutions, sulfonamides, antibiotics,
30



1 vitamins, and anaesthetics. With a greater number of
2 specific drugs and their more complicated treatment
3 regimes, it is more important than ever that certain
4 medications be immediately available and placed in compe-
5 tent hands. Thus, the pharmacy is assuming a greater
6 part in patient care.

7 The primary functions of a hospital pharmacy
8 are to make drugs and pharmaceuticals readily accessible
9 for treatment purposes and keep them under careful control;
10 to provide up-to-date information in order that the best
11 choice of medicinal products may be made by the physician;
12 as well as to assist both physician and nurse in the correct
13 administration of the product. Subsidiary or secondary
14 functions may include: purchasing of pharmacy products for
15 the hospital; manufacturing which may be merely dispensing
16 and compounding or may be a large scale operation; keeping
17 and originating financial and other records; and partici-
18 pating in the teaching of students, interns and residents,
19 and in medical staff education.

20 PURCHASE OF DRUGS

21 For purposes of this presentation, we
22 consider this item to embrace policy as well as practice.
23 Some of the hospitals have what is usually known as a
24 Pharmacy and Therapeutics Committee composed of members of
25 the medical staff. This Committee meets to exchange
26 professional views and, in general, to advise the medical
27 staff and the hospital administration on all matters
28 pertaining to the use of drugs in the hospital. Where a
29 pharmacist is on staff of the hospital, he or she is
30 usually secretary of such a committee. In the absence or



1 unavailability of a pharmacist, such as in most of the
2 smaller hospitals, the director of nurses would normally
3 act in such a capacity.

4 Basically, therefore, such a committee tends
5 to establish purchasing policy insofar as the needs of the
6 medical staff of that particular hospital is concerned.
7 Through experience, a list (a formulary is sometimes used
8 in this connection and a full account of this will be
9 found later on) of the main drugs required in the hospital
10 is eventually developed and this becomes a framework or
11 guide for continuing purchasing.

12 While individual application of the fore-
13 going principles may vary to some extent, the essential
14 point we wish to make is: it is the members of a medical
15 staff who decide the kind of drugs they wish the hospital
16 to acquire for their use in patient care. In the larger
17 institutions, the chief pharmacist is ordinarily respon-
18 sible for ordering the drugs required, utilizing his
19 detailed knowledge and experience as to quantities and
20 sources of supply, but in some instances, where there is
21 a purchasing agent on staff, the latter places the actual
22 order upon the specifications of the pharmacist. Again
23 this is a development based on specialization of function
24 in the more complex structure of the large hospital.

25 In the smaller hospitals, there likely will
26 be neither a pharmacist nor purchasing agent on staff.
27 The role of the latter is usually incorporated in the
28 duties of the administrator while the recommendations of
29 the medical staff as to pharmacy needs are carried out by
30 the director of nurses who may be the same person as the



1 administrator of the hospital. Since there is no pharma-
2 cist on staff, it is customary for the pharmacy service
3 in the smaller institutions to be under the supervision
4 of a designated member of the medical staff.

5 If any single aspect of purchasing policy
6 should be stressed, it is that quality of product must
7 continue to be the main criterion since the welfare of
8 patients is inseparably involved. Few, if any, hospitals
9 are known to have the staff and facilities that would be
10 required to do chemical analyses of every item purchased,
11 so that hospitals must depend on the known reliability of
12 the source of supply. This does not infer that there are
13 not a considerable number of reputable manufacturers and
14 suppliers, but in the final analysis, it is the individual
15 hospital's own experience, as reflected in the opinion of
16 its doctors and their clinical evaluation of drugs, that
17 will determine to a major extent where it places its
18 orders. We feel that our hospitals, regardless of size,
19 are very conscious of their responsibility in this matter
20 and continue to strive for the best possible operation
21 within their individual circumstances consistent with the
22 quality of product desired.

23 FORMULARY

24 As already indicated, the medical staff by
25 their treatment orders and prescriptions determine what
26 drugs are to be provided and it has been established that
27 eventually a pharmacy stock list is developed and is
28 written down as an inventory. In a number of instances
29 an attempt has been made to stabilize this list by
30 securing some authority other than the individual physician



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McCracken

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1 or pharmacist to determine what additions or deletions
2 may be made. This then may be the beginning of what is
3 termed a formulary.

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B/MR/hm 1 The Pharmacy and Therapeutics Committee, already referred
2 to, is the group normally giving direction to such a pro-
3 ject. In practice, the committee studies and grades the
4 effectiveness of pharmaceuticals on the list using as a
5 matter of principle that what is most effective is likely
6 to be the cheapest in the treatment of the patient. The
7 committee then decides what items are to be included in
8 the formulary and to this end may set up certain rules about
9 the admission of new drugs. Frequent revision is necessary
10 and individual staff members may make representation to the
11 committee regarding the inclusion of any item he may wish
12 to see in it.

13 Fully developed formularies usually contain
14 such items as a list of products by their official name
15 in English, together with a description of their properties,
16 chemical structure, dosage forms, and stock sizes.

17 THE CHAIRMAN: Mr. McCracken so we will have
18 the record clear, you speak of the official name. We
19 have had several words used to describe the medical products.
20 We have had chemical name and generic name and brand name.
21 What is "official name"?

22 MR. McCracken: This would be the generic-
23 chemical, interchangeable.

24 Indexing is very important and products may appear in
25 alphabetical order within groupings according to thera-
26 peutic use. In hospitals with extensive specialization
27 among medical staff, such groupings could be by medical
28 departments for ease of reference. Cross-indexing to
29 terminology commonly used for certain products by the
30 medical staff contribute to the practicality of such a



1 formulary.

2 MR. McCracken: This may bring in your
3 brand name idea.

4 A consideration of a formulary and pur-
5 chasing generally, brings up the subject of buying drugs
6 by "generic" name. The term "generic" relates to the
7 scientific or pure chemical name given to a particular
8 product. Items may be so identified or they may be pro-
9 duced under what is termed a "brand name" and it is in this
10 relationship that some confusion appears to exist.
11 Essentially, quality considerations aside, the ordering
12 of items by their generic name tends to restrict the number
13 of items stocked and to make for a more concise inventory.
14 The term "generic" should in no way connote a cheaper
15 product in the sense of an inferior one and it is here
16 the matter of quality arises. A drug may be ordered by
17 its generic name from what is known as a generic house,
18 and, as in the case of all purchases, the hospital must
19 be in a position to feel it can rely upon the product or
20 supplier. In point of fact, a number of hospitals do have
21 stocks in varying proportions as to drugs purchased under
22 their generic name and under designated brand names. The
23 preference and wishes of the medical staff for particular
24 items are important factors in the establishment of the
25 stocks and to the extent that these are professional
26 people with specialized knowledge of the effect of certain
27 preparations in their treatment regimes, must be accorded
28 full weight in any purchasing policy.

29 The matter of cost is naturally of consider-
30 able importance to hospitals, and sound purchasing has as
much applicability to drugs as to the many other hospital



1 commodities required. Reference has been made to varying
2 considerations affecting the nature and amount of drug
3 inventories, but the point to be emphasized at this time
4 is that the costs of drugs which are incorporated in the
5 per diem rates are entered at net invoice price - there is
6 no markup involved. Similarly, these drugs are Sales Tax
7 Exempt, with a consequent 9 - 10 per cent saving.

8 MR. McCracken: I believe that is a slight
9 error. It is as much as 11 per cent.

10 A further point pertinent to consideration of costs is that
11 hospitals have received and continue to receive substantial
12 discounts on their drug purchases. The larger hospitals
13 have tended to receive additional concessions by virtue of
14 their greater purchasing power and the possible advantage
15 to drug firms of having their products used in circumstances
16 where extensive clinical research and application is taking
17 place.

18 DISTRIBUTION - The distribution of drugs in
19 a hospital varies somewhat depending upon the size and
20 nature of the institution. In general, it may be said that
21 for the larger hospitals, distribution is in three forms.
22 First, certain supplies are maintained on the wards as
23 routine stock. Secondly, individual prescriptions are
24 filled in the pharmacy according to doctor's orders and
25 are returned to the ward for a particular patient. In this
26 respect, a hospital pharmacy operates in very similar fashion
27 to the retail pharmacy in that these numbered prescriptions
28 are kept on file for re-orders and/or reference. As may
29 be appreciated, the volume of prescriptions handled by a
30 hospital pharmacy is ordinarily much greater than in an



1 individual retail pharmacy. Thirdly, drugs are supplied
2 on doctors' orders for out-patients. In this latter
3 connection, it is generally the policy to provide just
4 sufficient of a drug supply to the out-patient as will
5 suffice until his next scheduled visit. In a number of
6 institutions, also, an emergency cupboard is maintained,
7 often in the nursing office, or, in large hospitals, on
8 the floors themselves, to minimize having to enter
9 pharmacy stores during night hours.

10 In smaller hospitals much the same pattern
11 is observed save that no out-patient clinics are involved.
12 Too, in those institutions where no pharmacist is on staff
13 and certain prescriptions must be obtained, arrangements
14 are made with a local retail druggist or druggists to provide
15 the required items. In some instances, arrangements have
16 been made by which a pharmacist from a local retail store
17 actually works part time in the hospital pharmacy.

18 Narcotics are very carefully safeguarded
19 and controls must meet the requirements of federal in-
20 spectors who make periodic visits to the hospitals. Other
21 controls used include departmental costing of issues to
22 floors for comparative purposes, therapeutic classifications
23 of use, and, periodic review of ward stocks. The supply
24 of drugs provided a ward for an individual patient is
25 generally restricted to three or four days with any unused
26 portion of the drug being returned to pharmacy stock after
27 inspection. Suitable arrangements are also possible for
28 the return of obsolete or expired drugs to suppliers for
29 credit.

30 Most hospitals, too, have adopted a policy



1 of an automatic stop order on certain drugs following a
2 specified period of time. For example, for such items
3 as narcotics a stop order might be effective after 48
4 hours, whereas, antibiotics might run for several days.
5 In any event, unless the physician's order should indicate
6 the exact number of doses to be administered, or has
7 specified the exact period of time during which the
8 medication is to be administered, or, unless the physician
9 has reordered a medication, all drug orders for such items
10 would be automatically discontinued.

11 ANALYSIS - This concerns the degree to which
12 drugs are analyzed or tested upon receipt at the hospital
13 or at least at some time following receipt. Analysis can
14 mean a number of things, but we can say that in very few,
15 if any, instances is there a chemical analysis done by
16 pharmacists in hospitals insofar as the general drug supply
17 is concerned.

18 Two main reasons may be cited for this:
19 firstly, even where a pharmacist is on staff, our experience
20 is that he is extremely busy doing his regular duties and
21 there literally is no time to do this type of work. Also,
22 the facilities required would be extensive and these ordin-
23 arily are not available in hospitals. The pharmacist
24 strives to purchase on the basis of known quality and
25 relies to a major degree upon the reputation of the supplier
26 and his own experience with that firm or firms. In short,
27 since he has not the time nor facilities to do a chemical
28 analysis, he tends to buy products which he has come to
29 depend upon for maintenance of quality standards.

30 One might well ask, upon what does the pharma-



1 cist base his dependence upon these items? This is a
2 combination of several things. There is a physical or
3 sense analysis in that he is able to do a visual inspection,
4 detecting variations in size, texture, etc., as well as
5 detecting, in some instances, odours which do not conform
6 with what he has come to expect. In short, this experienced
7 person, as in other lines of endeavour, develops certain
8 rule-of-thumb criteria which stand him in good stead. The
9 opinions of the medical staff as to patient reaction to
10 drugs prescribed are, of course, very important and these,
11 too, provide their measure of evaluation as to the
12 effectiveness of drugs and supplies.

13 STORAGE - The matter of storage could be
14 considered from several points of view, but in all cases
15 there is what might be termed a central stores or stock-
16 room. The size of the hospital will actually have a
17 bearing both on the amount and kind of storage space and
18 perhaps, as well, where it is located in the hospital. Two
19 of the major objectives should be uppermost in any storage
20 plan, viz., accessibility and control. The many variations
21 of physical layout and other hospital needs make generali-
22 zation as to the former rather meaningless for present
23 purposes. As for the latter, control, this is exercised in
24 a number of ways.

25 The storeroom is, of course, locked as is
26 the pharmacy proper when the staff are not present. There
27 is a definite policy regarding access to any of the pharmacy
28 supplies and only properly designated persons are given
29 this responsibility. Who is so designated does vary with
30 the size of the hospital, but there is normally no problem



1 during the day when the person in charge of the pharmacy
2 service is present. During the evening and night hours,
3 the night supervisor or person of equivalent status has
4 the responsibility of keeping the key to the pharmacy and
5 stores.

6 Entrance to the central stock is ordinarily
7 kept to a minimum, in two ways. First, a separate
8 emergency supply of drugs that might be required is
9 usually maintained in a small locked cupboard elsewhere in
10 the hospital and the person in charge of the night service
11 can gain entry to these supplies. Secondly, where a pharma-
12 cist is on staff, he may be called to the hospital in an
13 emergency. In the large cities, all-night retail pharma-
14 cies often are in a position to supply a needed item in the
15 event it is not available in the hospital stores.

16 Some drugs require specialized storage
17 facilities, for example, biologicals which must be refrigerated.
18 Some drugs deteriorate at a predictable rate, hence, they
19 must be used or replaced regularly. A number of items
20 such as ether and alcohol are inflammable and where purchased
21 in bulk should be stored in a fire proof location with
22 adequate ventilation to the outside. Poisonous materials
23 must be distinctively packaged, labelled and kept in a
24 locked cupboard. The main narcotics supply must be stored
25 in a vault or safe while narcotic prescriptions on the wards
26 must be kept in locked cupboards or drawers. These references
27 reflect some of the considerations which are attendant upon
28 providing storage for hospital drug supplies, and the
29 pattern followed is a typical one.

30 INVENTORY - We have already indicated that



1 the constituent items in an individual hospital drug
2 inventory will vary somewhat according to the size of
3 hospital and type of patient treated, and, according to
4 the preferences of the medical staff. We have also
5 referred to the fact that quantities purchased will vary
6 depending upon such factors as the availability of storage
7 and location of the hospital. The rates of usage, the
8 known perishability of certain items, and similar
9 consideration likewise will affect the amount of items
10 stocked. All of these bear upon the size of the inventory
11 carried in addition to any price consideration.

12 Physical inventory-taking is done by all
13 hospitals on at least a yearly basis, and many do spot
14 checks periodically. Perpetual inventories are not
15 necessarily maintained since in the opinion of many hospital
16 authorities the results do not warrant the volume of work
17 entailed. In taking physical inventory, members of the
18 business office are usually pressed into service, with the
19 pharmacist or other qualified persons acting in an advisory
20 capacity. Comparisons of yearly inventory figures together
21 with knowledge of any significant changes in hospital
22 operations which might affect drug inventories enable the
23 administrator of the hospital to keep in close touch with
24 the department's progress.

25 ACCOUNTING Accounting for drugs in hospitals
26 is now a relatively standardized procedure on two counts;
27 the development of the Canadian Hospital Accounting Manual
28 (Canadian Hospital Accounting Manual, Second Edition (1960),
29 published by the Canadian Hospital Association - P. 132.)
30 and the requirements of the various Hospital Plans.



1 Accordingly, while some interpretation may still be the
2 prerogative of the individual hospital, the form of the
3 accounting data tends to be predetermined.

4 Drugs are recorded in the books of the
5 hospital at cost price. As has already been indicated,
6 individual charges for drugs to patients no longer are
7 applicable under our present system of embodying drug
8 costs in the all-inclusive rate. However, for statistical
9 and control purposes, hospitals may provide their own
10 accounting devices to keep track of their drug usage by
11 department and/or by category of drug used.

12 Hospital budgets except in the Province
13 of Alberta must be examined by the Commissions in order
14 that a rate may be set for each hospital and the estimates
15 of drug expense, among many others, for the ensuing year,
16 come under scrutiny at such a time. Apart from the control
17 which continues to be exercised by the hospital itself
18 from its records and intimate knowledge of its patient load
19 and drug requirements, there is a second over-all element
20 of control in operation through the budget-approval system
21 of the Commissions.

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1 STANDARDS

2 This presentation would be incomplete were
3 we not to refer as well to the standards that have been
4 developed in relation to the accreditation service
5 available to hospitals 25 beds and over through the
6 Canadian Council on Hospital Accreditation. (C.C.H.A. -
7 Headquarters Bldg., 150 St. George Street, Toronto, Ont.)
8 There are additional eligibility requirements for accredi-
9 tation, but it is not thought essential that these be
10 elaborated on here. We would like to indicate first, in
11 very general terms, what this accreditation program is,
12 according to the Council's own description of its role:

13 The Canadian Council on Hospital Accre-
14 ditation is the body officially authorized
15 by federal charter to conduct an accre-
16 ditation program for Canadian hospitals.
17 The accreditation program is voluntary.
18 Accreditation is not compulsory either
19 on the part of the hospital or the
20 accrediting body. It is not licensure.
21 It is not governmental enactment. It
22 is a voluntary effort sponsored by the
23 Canadian Council on Hospital Accredita-
24 tion in co-operation with governing
25 boards, administrators and medical
26 staffs of hospitals to improve the
27 quality of patient care.

28 According to the 1961 edition of the
29 Canadian Hospital Director, 327 hospitals in Canada are
30 accredited and it may be of interest, therefore, that



1 these hospitals at least are known to be meeting the
2 following minimum standards of the accrediting agency,
3 insofar as hospital pharmacies and drug rooms are
4 concerned:

5 (a) There shall be a pharmacy directed
6 by a registered pharmacist or a drug
7 room under competent supervision.

8 (b) Facilities shall be provided for
9 the storage, safeguarding, preparation,
10 and dispensing of drugs.

11 (c) Personnel competent in their
12 respective duties shall be provided in
13 keeping with the size and activity of
14 the service.

15 (d) Records shall be kept of the
16 transactions of the pharmacy, and
17 correlated with other hospital records
18 where indicated. Such special records
19 as are required by law shall be kept.

20 (e) Drugs dispensed shall meet the
21 standards established by the Canadian
22 Formulary, British Pharmacopoeia,
23 United States Formulary and New and
24 Nonofficial Remedies and the drugs
25 dispensed shall be subject to perio-
26 dic review of a pharmacy committee of
27 the medical staff.

28 (f) There shall be an automatic stop
29 order on dangerous drugs.
30



1 SUMMARY

2 In summary, therefore, we wish to make the
3 following statements:

- 4 1. Hospitals have the responsibility of
5 providing the best possible patient care
6 at the lowest possible cost.
- 7 2. Hospitals have the responsibility of
8 providing the facilities necessary to
9 enable physicians of the medical staff
10 to give a good quality of patient care.
- 11 3. Hospitals have the responsibility of
12 providing drugs of an acceptable standard
13 as economically as possible.
- 14 4. The type, quantity and quality of
15 drugs prescribed for patients in hospital
16 is the responsibility of the medical staff.
- 17 5. Since very few hospitals in Canada
18 are in a position to make independent
19 analyses of drugs purchased, the hospital
20 itself must be able to rely on the product
21 or the supplier.
- 22 6. The hospitals of Canada are in favour
23 of any action which would reduce the cost
24 of drugs to the hospitals' patients as
25 long as this is not done at the expense
26 of quality, safety and potency of the
27 drugs.
- 28 7. The Canadian Hospital Association
29 recommends that the appropriate federal
30 government agency undertake, as far as



possible, more extensive testing, analysis and inspection of drugs.

Appendix I

CANADIAN HOSPITAL ASSOCIATION

History of Organization

In 1928 the Canadian Medical Association, realizing the need for a national co-ordinating body for hospitals, established what was called the "Department of Hospital Service". A function of this body was to undertake services on behalf of the hospitals of Canada including a general advisory service, the approval of hospitals for internship, the gaining of various tariff regulations, and assistance in the development of various hospital associations.

It became apparent, however, that there was a need for a national hospital organization which could officially represent the hospitals of Canada and more effectively act on their behalf when necessary. In 1931, the "Department of Hospital Service" invited representatives of provincial and regional hospital associations to a conference which resulted in the formation of the Canadian Hospital Council.

The Canadian Hospital Council worked closely with the Department of Hospital Service until 1945 when, as part of a re-organizational program, the Canadian Medical Association agreed that this Department should be discontinued and that the Council should take over the major portion of its activities.

In 1953, the delegates to the Assembly of the Canadian Hospital Council voted unanimously to change



1 the name to the Canadian Hospital Association and, alter-
2 nately, Association des Hôpitaux du Canada.

3 Membership

4 Provincial and regional hospital associa-
5 tions, the Catholic hospital conferences of Canada, and
6 the Canadian Medical Association constitute the active
7 voting membership. Associate membership includes volun-
8 tary, non-profit organizations in the health field, and
9 government departments which are interested in the opera-
10 tion of hospitals or in public health and welfare.

11 Administration

12 The Canadian Hospital Association is
13 governed by the Assembly which is comprised of delegates
14 appointed by the active members of the Association. The
15 Assembly meets annually at which time Association policy
16 is decided and problems common to hospitals are discussed.
17 The Board of Directors is elected by the Assembly and acts
18 as its executive body between meetings of the Assembly.
19 Every effort is made to have the Board of Directors repre-
20 sentative of the whole of Canada as well as of the groups
21 which comprise the active membership of the Association.

22 Financing

23 The Canadian Hospital Association is suppor-
24 ted by its active members on a fixed annual bed assessment
25 basis. With the exception of the staff at the head office
26 in Toronto, there are no paid employees. Many individuals
27 in Canada have, and are, voluntarily contributing a great
28 deal of time and work to assist the Association in
29 carrying out its services.



1 Availability of Services

2 The Association services are available to
3 organizations, hospitals, and individuals alike. In many
4 instances, however, where the information or assistance
5 sought can best be supplied at the local level, it is
6 suggested that the local association, council, or confe-
7 rence, be consulted first.

8 Government Liaison

9 One of the most important functions of the
10 Canadian Hospital Association is to maintain a close
11 liaison with the federal and provincial governments and
12 every endeavour is made to correlate the objectives of
13 governmental developments with those in the hospital field.

14 Conclusion

15 From this statement it will be seen that
16 the Canadian Hospital Association represents the indivi-
17 dual hospitals through their respective hospital associa-
18 tions and conferences. With but a few exceptions, prac-
19 tically all of the voluntary and municipal hospitals and
20 the tuberculosis sanatoria belong to these associations
21 and conferences.

22 Appendix II

23 HISTORY OF HOSPITALS

24 In the beginning, the hospital was not a
25 medical institution. The modern hospital has grown out
26 of the European mediaeval institution which had the same
27 name but a different function. The enthusiasm for reli-
28 gious pilgrimages at a time when commercial inns had not
29 appeared meant that many travellers were in need of
30 lodging. Religious organizations met this need by founding



1 and administering lodging houses known as hospitals.
2 Since many travellers were physically ill, nursing care
3 was necessary and this was developed, in time, to provide
4 medical consultation.

5 The original concept of hospital services
6 was more religious than medical in nature. Care and
7 treatment, as we know it today, was almost non-existent.
8 People admitted were received chiefly for isolation and
9 their chances of leaving the institution alive were
10 extremely poor. This fostered the old concept that hospi-
11 tals were places where one went to die.

12 Gradually, however, a change in this concept
13 began to occur. Skilled fraternal, religious and municipal
14 organizations began to provide facilities for the caring
15 of the sick.

16 The development of ether as an anaesthetic
17 in the 1840's had a profound effect upon hospitals by
18 contributing to progress in surgery. The teachings of
19 Florence Nightingale, particularly in relation to the
20 principles of sanitation and hygiene, made it possible to
21 control epidemics within the hospital and was the start of
22 the hospital as we know it today.

23 The first hospital in Canada was the Hotel
24 Dieu in Quebec founded in 1639. It was operated by a
25 religious order as were practically all hospitals founded
26 for some time after. Lay, voluntary, non-profit community
27 hospitals increased until they became the more numerous
28 group. In more recent years the municipal, civic and
29 "union" type of hospital has shown great increase parti-
30 cularly in the Prairie provinces.



1 Today we have some 1,354 hospitals divided
2 as follows: (Canadian Hospital Directory, 1961)

3 Hospitals in Canada - 1961

	<u>Hospitals</u>	<u>Adult Beds & Cribs</u>
4 Public General	889	91,306
5 Public Special	197	91,497
6 Private	154	4,346
7 Federal	<u>114</u>	<u>12,663</u>
8 Total	<u>1,354</u>	<u>199,812</u>

9
10 THE CHAIRMAN: Do you wish to add anything
11 to the brief at this time?

12 MR. McCracken: No sir.

13 THE CHAIRMAN: There is one question, on
14 page 19 you refer to the hospital budgets examined by
15 the Commissions. I don't think previously there has been
16 any reference to the Commissions. I just wonder if our
17 idea is correct. Would you tell us what they are?

18 MR. McCracken: In Ontario we have the
19 Ontario Hospital Services Commission which is the reimbur-
20 sing agency that pays the hospital bills. It might be
21 plans in other provinces. It might mean Departments of
22 Health. The use of the word Commission should be hospital
23 commissions, plans, something along that line.

24 THE CHAIRMAN: It is the government agency?

25 MR. McCracken: Government agency.

26 THE CHAIRMAN: There are some questions we
27 haven't dealt with that might be of interest to us. You
28 are representing the voluntary hospitals, not the provin-
29 cial and federal government hospitals?

30 MR. McCracken: Yes sir.



1 THE CHAIRMAN: With regard to the purchasing
2 of drugs, are you in a position to give us information as
3 to whether your hospitals or some of them normally call
4 for tenders for the supply of drugs or do they get the
5 drug in the ordinary way from the manufacturers?

6 MR. McCracken: Quite frequently they call
7 for tenders.

8 THE CHAIRMAN: That would be the larger
9 hospitals?

10 MR. McCracken: Usually the larger hospitals.

11 THE CHAIRMAN: Do you know whether they get
12 varying prices when they call for tenders?

13 MR. McCracken: Yes, they do.

14 THE CHAIRMAN: The hospitals usually, I
15 think we have some information on this from the Director's
16 book, do the hospitals generally get a bigger discount
17 from the manufacturers than the druggists do when they
18 are buying, not by tender but by drug manufacturers?

19 MR. McCracken: It does in some cases. We
20 do get a better price than say the retailer. I think if
21 you look at page 173 of the Green Book.

22 THE CHAIRMAN: We have some information on
23 that. I didn't know whether there was a difference
24 between the voluntary hospitals and the Government hospi-
25 tals.

26 MR. McCracken: No, the voluntary hospitals
27 receive that benefit.

28 THE CHAIRMAN: They would be on the same
29 footings?

30 MR. McCracken: Yes.



1 THE CHAIRMAN: This may be, perhaps, not
2 directly in line with our inquiry but has the Association
3 made any study of the rate of increase of the cost, the
4 cost of operating hospitals and the increasing cost of
5 drugs as part of that increase?

6 MR. McCracken: No sir.

7 THE CHAIRMAN: I was hoping we might get
8 some information whether since the hospital plans were
9 adopted in most of the provinces the rate has jumped up
10 very rapidly and to what extent that increase was due to
11 the rising cost in the use of drugs. That would relate
12 to the effort on the part of the hospitals with regard
13 to keeping down as much as possible the cost.

14 MR. McCracken: We haven't, but I think the
15 Commission will have and we hope to be able to get that
16 information.

17 THE CHAIRMAN: Would any of counsel like to
18 ask questions?

19 MR. HUME: I have one or two. Mr. McCracken,
20 I apologize for this; what position do you hold in the
21 Canadian Hospital Association?

22 MR. McCracken: I am Assistant Director.

23 MR. HUME: Assistant Director; are you a
24 doctor?

25 MR. McCracken: No sir, I am not.

26 MR. HUME: Mr. McCracken, just for my infor-
27 mation what do you mean by automatic stop order on
28 dangerous drugs? I don't understand that point.

29 MR. McCracken: If for example a narcotic
30 is prescribed by a doctor for a patient and nothing else



1 is said; that is, the nurse is not told at 48 hours you
2 start it, don't give it any more, it is not renewed.

3 MR. HUME: This has reference to the applica-
4 tion to the patient and not the purchase of the drug?

5 MR. McCracken: That is correct. We are
6 afraid if the doctor forgets to renew the order and it
7 just continues, the patient will be in danger.

8 MR. HUME: Without referring to any page
9 number, but the general area in the brief, it is my
10 impression, having read your brief yesterday and hearing
11 you read it this morning, that the underlying principle
12 your pharmacy committees in hospitals have, that motivate
13 them, is the quality of the drug.

14 MR. McCracken: That is correct.

15 MR. HUME: If you are satisfied that you
16 are getting good quality from one source you will, I
17 presume, carry on with that source?

18 MR. McCracken: Unless we can be sure we
19 will get a good quality from another source that is
20 cheaper.

21 MR. HUME: So that quality, therefore being
22 equal, it is price that, of course, takes over?

23 MR. McCracken: Yes.

24 MR. HUME: My purpose in asking you whether
25 I understood that aspect of your brief was simply this:
26 in this alleged controversy between generic and brand names
27 of drugs we have heard all were sold under their generic
28 name.

29 MR. McCracken: Yes.

30 MR. HUME: And to some generic names brand



1 names were added to identify the producer. You were here
2 yesterday, I believe?

3 MR. McCracken: Yes.

4 MR. Hume: You heard Mr. Thompson indicate
5 that there are some manufacturers who have research pro-
6 grammes and who are creative and there are other persons
7 who sell the drugs and don't have these extra costs. If
8 you are satisfied that the quality is good it doesn't
9 matter about where it comes from.

10 MR. McCracken: Basically that is true. It
11 doesn't matter to us where it comes from.

12 MR. Hume: Could you help by indicating
13 whether or not it is the experience of your pharmacy
14 committees -- as to whether or not they purchase more
15 brand name drugs than they do drugs under strict generic
16 name not knowing the source of where they come from
17 without the invoice?

18 MR. McCracken: I would have to give an
19 opinion. I think we would purchase more by brand name
20 than by generic name.

21 MR. Hume: Do you people purchase drugs,
22 do your committees, as far as you are aware, ever purchase
23 drugs by their generic names without knowing who supplies
24 them, where it comes from? Is there a manufacturer's name
25 attached to the generic name in some way so if it is wrong
26 you know somebody you can go back to?

27 MR. McCracken: In some way, there would
28 always be some way we would know where it came from.

29 MR. Hume: Then the generic name drugs you
30 purchase are associated with a brand or with a manufacturer?



1 MR. McCracken: With a manufacturer of known
2 quality.

3 MR. HUME: Thank you very much.

4 THE CHAIRMAN: The hospitals generally buy
5 from the manufacturer direct?

6 MR. McCracken: Yes.

7 THE CHAIRMAN: Automatically there would be
8 the manufacturer's name there?

9 MR. McCracken: The manufacturer must be
10 known one way or the other.

11 THE CHAIRMAN: If you are buying from the
12 manufacturer it is automatically associated with the manu-
13 facturer?

14 MR. McCracken: That is right.

15 THE CHAIRMAN: It is not a question of
16 making a difficult choice; in talking to the supplier, you
17 know when you buy from him you get his product as a rule?

18 MR. McCracken: That is right.

19 MR. FRAWLEY: Mr. McCracken, is the Canadian
20 Hospital Association made up in its membership of indivi-
21 dual hospitals or of provincial hospital associations?

22 MR. McCracken: Provincial hospital associa-
23 tions.

24 MR. FRAWLEY: The Ottawa Civic Hospital
25 would belong to your Association by virtue of the fact it
26 belonged to the Ontario Hospital Association?

27 MR. McCracken: That is correct.

28 MR. FRAWLEY: In the Province of Alberta
29 you say certain hospitals don't - voluntary hospitals
30 belong to this provincial association?



1 MR. McCracken: Yes sir.

2 MR. Frawley: What is your definition of
3 a voluntary hospital?

4 MR. McCracken: A hospital that is not
5 provincially or federally government-owned or a private
6 hospital.

7 MR. Frawley: Going to hospitals is generally
8 involuntary.

9 MR. McCracken: I am sorry I didn't under-
10 stand that.

11 MR. Frawley: The doctor sends you there.

12 MR. McCracken: It is not in that sense
13 voluntary.

14 MR. Frawley: In the Province of Alberta
15 does the University Hospital in Edmonton belong?

16 MR. McCracken: Yes sir, if it is of any
17 help to you there are 113 voluntary hospitals in Alberta.
18 112 of these belong to their provincial association and
19 through that to us.

20 MR. Frawley: Which hospital does not?

21 MR. McCracken: I am sorry I would have to
22 look that up. I have it in here.

23 MR. Frawley: It is not important. We have
24 straightened up whether the University Hospital in Edmonton
25 belongs to your Association.

26 MR. McCracken: Yes sir.

27 MR. Frawley: Speaking about generic as
28 against brand names you used the word in your submission,
29 official and the Chairman asked you to define it. I want
30 to show you the Pharmacopoeia of the Ottawa Civic Hospital



1 in case you haven't seen it. I would have to ask you to
2 take a quick look at it as I only have one copy and I
3 will have to take it back so I can read something from it.
4 It is the kind of thing you have seen many times. You
5 will notice the way in which the drugs are listed.

6 MR. McCracken: Right.

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D/JJ/nls

1 MR. FRAWLEY: I want you to look at the
2 names bracketed. I want you to have a general idea.

3 MR. McCracken: Yes sir.

4 MR. FRAWLEY: This is a document put out
5 by the Pharmacy Committee of the Ottawa Civic Hospital,
6 as you would expect it to be, and I read this, "This work
7 includes the drugs commonly used in our Hospital. The
8 table of contents follows a therapeutic classification.
9 All drugs are listed under their generic names with the
10 trade names where useful being given in parenthesis."

11 MR. McCracken: Yes.

12 MR. FRAWLEY: I take it therefore that one
13 can use as an equivalent for the word "official" the word
14 "generic"?

15 MR. McCracken: Correct. Or "chemical" or
16 a number of other words.

17 MR. FRAWLEY: For instance, when we come to
18 the list of antibiotics that we heard a lot about yesterday,
19 we find that the Ottawa General lists under the word
20 "Tetracycline" "(HCL)" in brackets, (Achromycin, Panmycin,
21 Steclin, Tetrex, Tetracy, Polycycline) Terramycin, etc."
22 So that as far as the Ottawa Civic Hospital is concerned
23 those brand name antibiotics are all Tetracycline HCL.

24 MR. McCracken: Yes.

25 MR. FRAWLEY: Just so there will be no
26 feeling on anyone's part that there is any -- and this
27 certainly is a secondary matter -- that there is any looseness
28 in my province, I ask you to talk to me for just one short
29 moment about what you say on page 19:

30 "Hospital budgets except in the Province of



1 Alberta must be examined by the Commissions--"
2 -- and you have indicated what you mean by "commissions".

3 You know, of course, that there is no
4 hospital commission administering the federal-provincial
5 hospitalization plan in Alberta.

6 MR. McCracken: That is correct.

7 MR. Frawley: You are aware that unlike the
8 Province of Ontario where I have to pay a premium every
9 three months whether I go to hospital or not, there is
10 nothing of that sort in Alberta.

11 MR. McCracken: Yes.

12 MR. Frawley: And there is no sales tax to
13 finance the hospital scheme, and that, I suppose, is why
14 there is not any commission supervising the hospital budgets
15 because there is no such body. You are aware that the only
16 additional cost to the patient in connection with the
17 Alberta Hospital Scheme is that he pays a deterrent fee
18 of \$2.00 a day when he is in hospital, and when he is not
19 in hospital, he pays nothing. That is a broad and over-
20 simplified description of the scheme in Alberta.

21 MR. McCracken: Do you want me to reply to
22 that, Mr. Frawley?

23 MR. Frawley: Yes indeed.

24 MR. McCracken: Are you saying, sir, he
25 does not have to pay for this hospital care?

26 MR. Frawley: He doesn't have to pay for
27 this hospital care.

28 MR. McCracken: Is that what you are saying?

29 MR. Frawley: He doesn't have to pay for
30 his hospital care by way of insurance premiums. When he



1 leaves the hospital, if he is there for ten days, he gets
2 a bill for \$10.00. I think it has gone up now to \$2.00,
3 so he gets a bill for \$20.00 if he has been there ten days.
4 That is my understanding, is that yours?

5 MR. McCracken: That is true. That is all
6 he pays at that time, but he also pays taxes which are to
7 pay for his hospital care.

8 MR. FRAWLEY: He either pays taxes or it is
9 taken out of the ground. You have heard about what happened,
10 haven't you?

11 MR. McCracken: Yes, but it is paid for, one
12 way or the other. It is paid for.

13 MR. FRAWLEY: Yes. It is not tax-free in
14 Alberta. I am sure you made that statement because it was
15 not, strictly speaking, an accurate statement and I take
16 no exception to it.

17 MR. McCracken: The answer for singling out
18 the Province of Alberta is because the Province of Alberta
19 is the only province that does not examine a budget prior
20 to the incurring of expense, but they examine the hospital
21 records after the year end.

22 MR. FRAWLEY: Yes. Please understand I never
23 object to singling out the Province of Alberta. The
24 Province of Alberta has probably singled itself out by
25 sending me to attend these hearings of the Commission.

26 THE CHAIRMAN: I suppose, Mr. Frawley, you
27 believe in the advertising maxim that all publicity is
28 good.

29 MR. FRAWLEY: The chairman was asking you
30 about the relationship between the prices which hospitals pay



1 and the public pay, and the patient pays and the druggist
2 pays and because of that it might be interesting if I
3 put on the record the prices which the University Hospital
4 in Edmonton pays for a representative number of drugs.
5 Let me put it to you as well as I can -- and I will be very
6 glad to give you this document and to file it with the
7 Commission -- I would like to reprint it and clean it up
8 a little bit but I will be very glad to file it. That is
9 undoubtedly why it was sent down to me for the assistance
10 of the Commission, and I will be very glad to do that.
11 I would like an opportunity to have it reproduced in a
12 handier form.

13 THE CHAIRMAN: We will give it exhibit
14 number T9.

15 MR. FRAWLEY: This is a letter from Dr. F.
16 B. Rodman who gave evidence before the Commission at the
17 Edmonton hearing to Dr. M. G. McCallum, the Deputy Minister
18 of Health at Edmonton, dated September 21st, 1961 to which
19 is attached a statement.

20 The letter itself is short and merely says:
21 "Dear Dr. McCallum: Please find enclosed
22 estimates of drug cost in the University
23 Hospital, National Drug Wholesale, Cost to
24 the Druggist and the list or retail price.

25 Trusting this is satisfactory, I am

26 Yours sincerely

27 (Signed)
28 F. B. Rodman"

29 The attachment is called "Estimates of Drug Cost" and let
30 me call your attention to the fact that under the usual



1 heading of "Corticoids" -- and that seems to be a word that
2 is used in various ways. There is also a word "Corticos-
3 teroids", is there not, that means the same thing?

4 MR. McCracken: I am sorry, I am not
5 qualified to answer.

6 MR. FRAWLEY: Now Prednisone and in brackets
7 Meticorten, and in further brackets Schering, the University
8 Hospital pays \$1.50 per hundred for the five milligram
9 dosage. The wholesale price to the druggist is 40% off
10 list, and is \$13.62, and the list price is \$22.70.

11 MR. HUME: I think, Mr. Frawley should also
12 put on the record the quantity involved in that if they
13 are not buying one package -- at that price they are buying
2 14 a large quantity, and I think the quantities are part of
15 the picture and it should be added.

16 MR. FRAWLEY: That is right, it is part of
17 the picture, and I rather agree with my friend's description
18 of the word "picture", and I would be very glad to obtain
19 from the University Hospital the quantities which they buy
20 at these prices. I am simply told this is the price per
21 hundred. But continuing the comparison --

22 MR. HANSARD: I wonder if I might interrupt
23 my friend for just a moment. The last reply he got out of
24 this witness is that the witness did not regard himself as
25 being qualified to answer the question. Mr. Frawley has a
26 wonderful system of reading an interminable amount of
27 material that he wants to get on the record, and if the
28 witness should happen to say, "I am sorry, I am not qualified
29 to answer yes or no," it is still on the record. Perhaps
30 we should qualify the witness first.



1 THE CHAIRMAN: It is on record as a question
2 that is answered, really.

3 MR. HANSARD: That may be. It is on the
4 record, and I have a great fear of things that get on the
5 record, Mr. Chairman, because they are always used whether
6 they have been answered or not.

7 MR. FRAWLEY: I might as well address myself
8 to that right now and then take the Commission's directions.
9 The Commission, the Chairman, was interested and asked the
10 witness if he knew the relationship between the prices
11 which the hospitals paid and the prices which the druggists
12 paid and the prices which the patients paid. It happens
13 that I have that information in connection with the
14 University Hospital and my friend, Mr. Hansard, objects to
15 the way in which I am, as he says, putting it on the
16 record.

17 Admittedly that is what I am doing, putting
18 it on the record. I will bring someone from the University
19 Hospital here and have him come before the Commission and
20 have it on the record if you like. Should I do that, sir?

21 THE CHAIRMAN: The point is at the moment
22 counsel is questioning a witness. You are not yourself a
23 witness. You can provide us with that information as a
24 witness yourself as far as that goes, but at the moment you
25 are questioning the witness and you are not putting in
26 anything as a witness yourself.

27 MR. FRAWLEY: I am quite aware of the point
28 of my friend, Mr. Hansard's, objection. I put it to the
29 witness: Witness, let me explain that the University
30 Hospital in Edmonton pays \$1.50 a hundred for Schering's



1 Meticorten and lists the price in Edmonton as \$22.70, and
2 the price to the druggist is \$13.62, and the price to the
3 University, as I said, is \$1.50. The witness says, "Mr.
4 Frawley, if you say so." That is Mr. Hansard's objection,
5 and I am quite aware of that.

6 MR. HANSARD: The witness has not said any
7 such thing.

8 MR. FRAWLEY: Then I will ask the witness,
9 do you know whether or not that is the list price of
10 Schering's Meticorten in Edmonton, \$22.70 and do you know
11 whether or not the druggist pays 40% off that list which
12 is \$13.62?

13 MR. McCracken: No sir, I don't.

14 THE CHAIRMAN: Unfortunately we are not in
15 the position of having that information and you have asked
16 him a question that he cannot answer.

17 MR. FRAWLEY: I would like this entered as
18 an exhibit and you have been good enough to give it an
19 exhibit number already, and I don't know how strict or
20 precise this Commission is, because it is the first time
21 I have ever appeared before it in connection with the
22 obtaining of information.

23 This information was sent to me, not for
24 my personal information, but for the information of the
25 Commission in this enquiry, and I am undoubtedly in your
26 hands, and I am aware Dr. Rodman would regard it as a
27 very serious inconvenience to come here, but I am certain
28 Dr. Ross would ask him to come and have him come at Dr.
29 Ross' expense.

30 I think it is an important matter. I think



1 so, doubly, because you, yourself, Mr. Chairman, were
2 struck with the matter and asked the witness about it.
3 Would it be proper for me to read this into the record now
4 subject to having it verified by Dr. Rodman in some
5 fashion?

6 THE CHAIRMAN: You might read it into the
7 record, but not through the course of examination of the
8 witness. You are supplying it as information on your
9 responsibility as counsel with the knowledge of the facts
10 given to you.

11 MR. FRAWLEY: That is right.

12 THE CHAIRMAN: We can accept that. We don't
13 expect that everything be put in in a formal fashion as in
14 court proceedings. Where counsel gives us a statement of
15 fact and is responsible and assures us it is correct, we
16 will normally accept that as a fact unless we have some
17 reason for thinking it is not correct or it is contradicted.

18 MR. HUME: You have already marked this as
19 an exhibit and I take it this is now to expunged because
20 I think if it is to be an exhibit -- and I have known Mr.
21 Frawley a long time and he is not trying to indicate any-
22 thing to the Commission other than his instructions -- but
23 this document which he indicated does not in fact show the
24 quantities involved. You know, anybody knows, I am no
25 expert but it seems to me it is basic to be able to under-
26 stand prices. It does not indicate the services required
27 in selling a product to a wholesaler or a druggist as com-
28 pared to the services or lack of them to hospitals, and I
29 think if Mr. Frawley is going to prepare this exhibit, he
30 should prepare it properly indicating what is involved in all



1 aspects of the prices, so it will have some meaning. The
2 way it is now, I submit, it does not mean anything, it is
3 just a list of numbers.

4 MR. FRAWLEY: It means something or my
5 friend would not be objecting to it.

6 THE CHAIRMAN: Maybe he is a little
7 apprehensive of the difference.

8 MR. FRAWLEY: As to the services, here we
9 have a hospital administrator who can tell us what the
10 different services are.

11 What different services are involved if the
12 University Hospital in Edmonton ordered one thousand
13 tablets in hundreds, ten bottles of one hundred each of
14 Schering's Meticorten and a druggist ordered ten bottles of
15 100 tablets each of Schering's Meticorten, and a patient
16 bought on a prescription ten bottles of 100 tablets each
17 of Schering's Meticorten from a druggist? Can you give the
18 Commission some indication of the degree, of the differing
19 degree, of services that would be involved in those three
20 purchases?

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MT/dpw

1 MR. HANSARD: Before the witness answers
2 the question, may I point out my friend Mr. Frawley
3 qualified him as a hospital administrator. I am not sure
4 that is what he is. Perhaps he could tell us first what
5 he is. He is interested in hospitals I know, and he has
6 an important post, but is he a hospital administrator?

7 THE CHAIRMAN: Will you put on the record
8 what your actual position is? You are Assistant Director
9 of the Hospital Association?

10 MR. McCracken: Yes, sir.

11 THE CHAIRMAN: Are you familiar with hospital
12 administration yourself?

13 MR. McCracken: Yes, sir.

14 THE CHAIRMAN: Have you had experience in
15 that field?

16 MR. McCracken: Yes.

17 THE CHAIRMAN: Do you regard yourself as a
18 hospital administrator?

19 MR. McCracken: Yes, sir.

20 THE CHAIRMAN: Are you in a position to
21 answer the question Mr. Frawley has put to you?

22 MR. McCracken: In one individual
23 instance to quote the services that are involved
24 with one individual sale, I don't think it is possible to
25 answer that question.

26 MR. FRAWLEY: I think my friend Mr. Hume
27 is not concerned with one sale. He is concerned with
28 services involved in merchandising. In other words, the
29 Schering Company supplied the University Hospital in
30 Edmonton, supplied Tamblin's Drugstore in Edmonton.



1 MR. McCRACKEN: The services that a manufac-
2 turer might supply a hospital, there are quite a few.

3 MR. FRAWLEY: Tell me.

4 MR. McCRACKEN: Education could be one of
5 these: supplying in drop shipments, that is a portion of
6 the order at a time; supplying of emergency items on
7 demand; service calls at all hours of the day or night.
8 These are some of the services which a manufacturer could
9 give a hospital and does.

10 MR. FRAWLEY: And do, if necessary?

11 MR. McCRACKEN: Yes, and do.

12 MR. FRAWLEY: The drugstore on the corner
13 wouldn't need or ask or expect this kind of service?

14 MR. McCRACKEN: It might get them too, yes.

15 MR. FRAWLEY: So the hospital you would
16 think gets more services rather than the ordinary garden
17 variety of retail pharmacy?

18 MR. McCRACKEN: That is difficult to answer.
19 In all the hospitals I have been in, we have had a very
20 good relationship, and received very good service, but I
21 have never been in a retail pharmacy, so I don't know.

22 MR. FRAWLEY: My friend Mr. Hume is there-
23 fore emphasizing the fact that along with this price of
24 \$1.50 against \$13.52, a lot of services ---

25 MR. HUME: I am not going to let Mr. Frawley
26 put words in my mouth.

27 THE CHAIRMAN: I think Mr. Frawley is now
28 giving an opinion on what the witness has said. I think
29 we will have to draw our own conclusions.

30 MR. HUME: I hate to keep popping up. Is



1 T-5 on the record, or has it been expunged?

2 MR. FRAWLEY: The Chairman has permitted me
3 to put it on the record on my own.

4 MR. HUME: He said not when you are cross-
5 examining a witness. I have some exhibits. Do we have
6 T-5 or don't we? It doesn't matter.

7 THE CHAIRMAN: I think we will leave it.
8 We will reserve this number for it, and that will depend
9 how it comes in, in value.

10 MR. FRAWLEY: I will continue now and I
11 have no further questions to ask Mr. McCracken. Now,
12 continuing with this list, sir, Prednisolone, Meticor-
13 talone, Schering, the University Hospital have \$7,
14 5-milligram dosage.

15 THE CHAIRMAN: Are you asking a question?

16 MR. FRAWLEY: No, no.

17 THE CHAIRMAN: Do this subsequently. We
18 have a witness on the stand.

19 MR. FRAWLEY: You expect me to do that some
20 other time?

21 THE CHAIRMAN: After the witness is finished.

22 MR. FRAWLEY: Oh, I am sorry.

23 THE CHAIRMAN: We don't want a lot of evi-
24 dence going in by somebody else while we have a witness
25 here.

26 MR. FRAWLEY: Fine.

27 THE CHAIRMAN: Have you any further questions?

28 MR. FRAWLEY: No.

29 THE CHAIRMAN: Anyone else?

30 MR. J.C. TURNBULL: Turnbull, Canadian



1 Pharmaceutical Association. Just one or two points of
2 clarification, Mr. McCracken, in item 5 of your summary
3 which refers to the possibility of the Canadian Hospitals being
4 in a position to make an independent analysis of drugs
5 purchased, just for the record and for my own understand-
6 ing, this is based on the time, equipment and personnel
7 that may be required, but I assumed from my discussions
8 with you earlier that it is readily acknowledged that the
9 pharmacist's qualifications, if the equipment was available
10 to him, would permit such an analysis to be made?

11 MR. McCracken: Yes, if he is a qualified
12 pharmacist, but we don't have qualified pharmacists in
13 all of our hospitals.

14 MR. TURNBULL: Going on to item No. 6 I
15 assume as well that you would wish the words, or the word
16 "research" added to "as long as it is not done at the
17 expense of quality, safety and potency of drugs". The
18 hospitals are of course very interested in quality, and
19 would not want anything to happen to it?

20 MR. McCracken: Research in drugs. No, not
21 at all.

22 MR. TURNBULL: In No. 7 you make reference
23 to the possibility of further and more extensive testing
24 analysis and inspection of drugs by an appropriate federal
25 agency. You are thinking there of a broadening inspection,
26 inspection control rather than placing the responsibility
27 for drug purity upon a federal agency? We don't particu-
28 larly want a government agency to certify to every batch
29 that comes off the manufacturer's production line. It
30 would be nice; it would be quite idealistic, but



1 impractical.

2 MR. McCRACKEN: This is why we have said in
3 this item No. 7 "as far as possible".

4 MR. TURNBULL: Yes.

5 MR. McCRACKEN: If it is not too idealistic
6 to have this certification, then we would prefer to have
7 it.

8 MR. TURNBULL: Earlier it was suggested that
9 it would be very interesting to know the cost of drug
10 therapy in the overall patient-day cost, particularly in
11 view of the government schemes of the past year or so,
12 and I believe that such figures are available from British
13 Columbia, Saskatchewan and what-not who have had this
14 done for quite a number of years. Would it not be
15 extremely advantageous, particularly in a discussion of
16 this nature, if we were able to enquire into and establish
17 some figure relative to use of modern so-called high-
18 priced drugs towards the reduction of actual patient's
19 stay in the hospital, and therefore the relative reduction
20 in overall hospital costs per patient? Do you think that
21 such information could be obtained?

22 MR. McCRACKEN: If you are asking me there
23 would it be advisable to have this information or would
24 it be desirable to have this information, by all means,
25 I would say yes, it would be very desirable. If you are
26 asking if the Canadian Hospital Association can provide
27 this information, no, I am sorry, we cannot.

28 MR. TURNBULL: I think it would be most
29 advantageous though to attempt to relate or attempt to
30 have the figures and relate the cost of drugs and the



1 overall effect that it might have on bed occupancy.

2 MR. McCracken: I think it would be very
3 difficult to separate the cost of drugs plus their effect
4 on patient's stay, to segregate that out from the other
5 factors that have reduced the patient's stay.

6 MR. TURNBULL: Mr. Chairman, there is only
7 one matter - Mr. Frawley's reference to Dr. Rodman's
8 letter, and the information that he brought forth. May
9 I point out to the Chairman this is based on estimates,
10 as Mr. Frawley has suggested.

11 THE CHAIRMAN: When Mr. Frawley goes into
12 this with a view to putting it on the record, we will
13 get from him the source of all the information.

14 MR. TURNBULL: Thank you.

15 THE CHAIRMAN: Mr. MacLeod, have you any
16 questions?

17 MR. MACLEOD: Perhaps one I might ask the
18 witness about. It appears to be established by the evi-
19 dence that to a very great extent in Canada hospitals
20 bypass the wholesaler and purchase direct from the manu-
21 facturer. Do you know anything about the situation in
22 the United States?

23 MR. McCracken: No, sir, I don't.

24 THE CHAIRMAN: Are there any other questions?
25 Thank you, Mr. McCracken. We will have a short recess at
26 this time.

27
28 --- Short Recess

29
30 THE CHAIRMAN: We will proceed now with the



1 presentation to be made by the Pharmaceutical Manufactu-
2 rers' Association. Mr. Hume?

3 MR. HUME: Thank you, Mr. Chairman, your
4 honours, may I just say at the outset unfortunately the
5 gentleman who has some additional copies of the brief
6 seems to have disappeared temporarily, and he will be
7 back shortly and if there is anybody who has not a copy
8 of the brief and who would like one, we will certainly
9 see that they are distributed.

10 MR. Chairman, before I call upon Mr. Conder
11 to make the presentation, I think it is advisable if I
12 indicate in a very brief statement the area in which this
13 Association moves in order to avoid the misunderstanding
14 that I think arose in connection with the Association's
15 presentation to the Ontario Selective Committee. The
16 Association which will be described in due course by Mr.
17 Conder, is what is popularly known as a trade association.
18 It represents a percentage of the ethical pharmaceutical
19 manufacturing industries, and it operates in a manner in
20 which certain areas are not covered.

21 The Association, and Mr. Conder in parti-
22 cular, has no information with respect to, for example,
23 discount practices of the members, or their costs or
24 their prices or their policies with respect thereto, and
25 we found when we appeared before the Ontario Select
26 Committee, a great number of questions were directed to
27 Mr. Conder as if he were in fact a manufacturer; the kind
28 of questions that were directed to Mr. Thompson yesterday.
29 I thought I could perhaps avoid some misunderstanding
30 early if I indicated within the areas that this



1 Association operates. It does not consider under my
2 advice anything to do with price, discounts, or sales
3 practices.

4 This presentation has been prepared as a
5 broad picture of the industry because, Mr. Chairman, as
6 the Director has indicated in his Statement of Evidence,
7 antibiotics and tranquilizers do not necessarily - they
8 may be representative of some of the pharmaceutical
9 manufacturing industry, but they are not the pharmaceutical
10 manufacturing industry, and what we have tried to do in
11 this submission is assist the Commission by a broad pic-
12 ture of the industry.

13 In due course you will receive certain infor-
14 mation with respect to sales and costs, and it will be
15 explained to you at that time the information gained by
16 the Association was obtained by using an independent firm
17 of chartered accountants who then circularized the members
18 under a code number, so that there is nothing in the
19 Association's files whatsoever to do with these areas.

20 Now, with that preliminary, Mr. Chairman, I
21 have pleasure in calling on Mr. Conder, who I presume can
22 remain seated, with your permission, while he reads his
23 submission.

24 THE CHAIRMAN: We do not object to that.
25 Unfortunately the acoustics are not good so it is some-
26 times difficult for people to hear. They hear a little
27 better if you are standing, but if you remain seated
28 perhaps you will raise your voice a little more than other-
29 wise would be necessary.

30 MR. CONDER: With your permission, Mr.



1 Chairman, I would like to start standing. Mr. Chairman
2 and Members of the Restrictive Trade Practices Commission.
3 This representation is being respectfully submitted to you
4 on behalf of the Canadian Pharmaceutical Manufacturers'
5 Association.

6 I am Stanley Nesbitt Conder, General Manager
7 of the Association. With me today is Brian Dixon, Ph.D.,
8 Assistant Professor, Commerce & Business Administration,
9 Queen's University, Kingston, who is Economic Consultant
10 to our Association.

11 Presented with this brief is an independent
12 economic report on the pharmaceutical manufacturing
13 industry, prepared by Dr. Brian Dixon. This economic
14 report has been filed with your Committee in support of
15 our representation, under Appendix C. Dr. Dixon is
16 prepared to answer any questions concerning his report,
17 following this presentation. In addition, we are inclu-
18 ding under Appendix D a copy of the submission which this
19 Association made before the Ontario Government's Select
20 Committee on Drugs in 1960.

21 INTRODUCTION

22 The Canadian Pharmaceutical Manufacturers'
23 Association was founded in 1914, and was incorporated
24 under the Dominion Companies Act in 1959. It represents
25 56 companies engaged in manufacturing and distributing
26 ethical pharmaceutical preparations in Canada. As the
27 Commission is aware, the term "ethical" refers to pharma-
28 ceuticals dispensed on doctor's prescription and those
29 not advertised to the public, as different from proprietary
30 or patent medicines which are advertised to the public.



1 THE CHAIRMAN: It might be said that the
2 use of the word "ethical" as applied to this kind of drug
3 does not mean other drugs are unethical?

4 MR. CONDER: No, sir. It is purely trade
5 terminology.

6 As might be expected, some of our companies
7 also make proprietary medicines to varying degrees, but
8 our Association does not represent this field of medica-
9 tion.

10 An outline of our Association is appended to
11 this representation under Appendix A, while a list of the
12 membership is attached under Appendix B.

13 On behalf of our companies, I wish to thank
14 the Commission for giving our Association this opportunity
15 to appear before you. We requested permission to make
16 this representation with the hope that it will serve to
17 engender a better understanding and appreciation of pharma-
18 ceutical manufacturing in Canada.

19 Erroneous reports to the contrary, this
20 Association has not at any time made a request to your
21 Commission for a private rather than a public hearing. In
22 fact, we welcome a public hearing on the grounds that
23 Canada's pharmaceutical manufacturing industry is opera-
24 ting in the best public interest, and that profits and
25 manufacturers' selling prices are reasonable and consistent
26 with good business practice.

27 As requested by the Commission, our basis
28 for reference is the statement of material relating to
29 the manufacture, distribution and sale of drugs, prepared
30 by the Director of Investigation and Research and referred



1 to as the "green book".

2 Our remarks will be predicated on this
3 statement of material.

4 The green book is an interesting summary of
5 some aspects of pharmaceutical manufacturing in Canada
6 and the author is to be complimented for the manner in
7 which he clarified many of the intricacies of a most
8 complex industry.

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F/MR/hm

1 As might be expected, we do disagree with
2 certain comments and opinions which appear in the Green
3 Book particularly the use of hearsay evidence from domestic
4 and foreign sources, but we realize that this was included
5 not as a foregone conclusion but merely as an attempt to
6 elicit more factual information.

7 We hope that our comments will not be mis-
8 taken as an all-encompassing criticism of what we are
9 certain has been a time consuming task of considerable
10 magnitude.

11 On the premise that the Green Book is not a
12 report but a compilation of largely unsubstantiated material,
13 we regret that it has been and is even now being looked
14 upon in some quarters as an indictment of our industry by
15 the Government of Canada. This is borne out by the press
16 reports which were based on the Green Book during its
17 initial public appearance. And upon the fact that some
18 witnesses appearing before this Commission have used un-
19 substantiated statements from the Green Book as evidence
20 in their own representations.

21 We further recognize that the Commission is
22 aware of this situation, and that it will be considered in
23 the preparation of the final report based on your findings.
24 But we wish to offer this situation as prima facie evidence
25 that the criticisms which have been levelled at us are in
26 many instances fostered by misunderstanding and opinion
27 rather than fact and perspective.

28 In many cases the services being carried on by
29 our industry as a major supplier to the medical profession
30 have been distorted to the point where it has become almost



1 fashionable to criticize drug costs and related factors.

2 Our companies are indeed doing an honest
3 and conscientious job of supplying to Canadians the finest
4 medication available, and their profits and prices are not
5 out of line with the economic risks and costs involved
6 in providing this service to the professions and the
7 public.

8 THE CHAIRMAN: These are your considered
9 opinions about which you will be giving us data as you
10 go along?

11 MR. CONDER: That is correct sir.

12 Whatever the ultimate findings of this
13 Commission, we hope and trust that the Commission's final
14 report will at least help to alleviate the almost irrepar-
15 able harm which has resulted unwittingly and unintentionally
16 from certain statements contained in the green book.

17 THE CHAIRMAN: You will be itemizing these
18 to some extent I suppose?

19 MR. CONDER: Yes, that is right.

20 THE CHAIRMAN: That is something the
21 Commission will want to know about.

22 A RESUME OF THE INDUSTRY

23 While Canada's pharmaceutical manufacturing
24 industry was born in the middle 1800's, it did not gain
25 a measurable economic stature until the post World War
26 II years. It is within this past two-and-a-half decades,
27 and the last one in particular, that pharmaceutical manu-
28 facturing has undergone a transition unprecedented in its
29 history.

30 Penicillin marked the beginning. U. S.



1 manufacturers operating under the emergencies of the war
2 effort were called upon to find the means of mass-producing
3 our first antibiotic, and to a lesser extent Canadian
4 industry played its role in the exacting drama then unfolding.
5 Ayerst set up one of the earliest known plants for
6 penicillin production. In fact, it supplied the first
7 Canadian-made penicillin to our Armed Forces, closely followed
8 by Connaught and later by Merck. These three provided
9 Canada with penicillin long before it was available from
10 any other source.

11 Other Canadian firms followed suit and when Sir
12 Alexander Fleming came to North America in 1945, he paid
13 tribute to the Canadian industry's part in the development
14 of the product he had discovered:

15 "Penicillin has had a romantic career. It
16 was born in a culture plate where it wasn't wanted and it
17 was developed in the worst of all wars. I thank Canadian
18 manufacturers for their share in this great work... three
19 months ago Canada was ahead of the U.K. in the production
20 of penicillin. You have done very fine work under difficult
21 circumstances."

22 The resulting evolution in the field of
23 therapeutic substances brought with it a phenomenal growth
24 in the size and operating capacity of the manufacturing
25 plants, to meet the need for increased production to supply
26 the medical profession with the new tools of discovery.
27 Almost overnight, in terms of industrial development, the
28 industry in North America changed from a commercial
29 nonentity to one of the most vital factors in the health
30 of the people.



1 Companies such as Lederle, Parke Davis and
2 Pfizer which had introduced Aureomycin, Chloromycetin and
3 Terramycin respectively, were entering a new period of
4 development and growth. Wholly-owned Canadian companies
5 such as Frosst and Horner, were also investing their
6 reserves in research facilities to maintain their positions
7 in the market, on the premise that no company can hope to
8 survive without access to research.

9 The boom in growth produced economic hazards
10 for the companies which were only coming to learn that theirs
11 was a risk industry. New discoveries were rewarding, but
12 the cost of research and development was high. Lilly lost
13 \$850,000 on but one research failure, while SKF underwrote
14 \$750,000 on another.

15 THE CHAIRMAN: Are you speaking now of the
16 United States or Canada?

17 MR. CONDER: No. This would be based on
18 the North American operations of the company.

19 THE CHAIRMAN: Can you give us the source
20 of this information?

21 MR. CONDER: Oh, I am sorry, sir. Yes.
22 Regarding the Lilly project, this covered a 15 month
23 clinical survey on Carbutamide a Sulfanilamide derivative
24 for the treatment of diabetes. This clinical study turned
25 up so many side effects that Lilly abandoned the project.

26 THE CHAIRMAN: You got that information from
27 Lilly did you?

28 MR. CONDER: Yes sir, that is correct. Now
29 the one under the S.K.F., this was a new product to
30 prevent vomiting and to control psychosis. A 100 Internists



1 pronounced this new remedy "excellent" S.K.F. decided,
2 however, that this product was not significantly better
3 than others on the market, and it was not completely free
4 of side effects. This is another example of why the
5 decision not to market a drug can be costly.

6 MR. FRAWLEY: Is this the Canadian S.K.F.
7 or the U. S. S.K.F.?

8 MR. CONDER: This is the U.S. S.K.F., Mr.
9 Frawley.

10 In 1958 alone, the pharmaceutical industry
11 in North America worked on 114,600 different chemical
12 substances in its laboratories. Less than 40 reached the
13 market. 2.

14 MR. CONDER: I would request that the
15 reference number 2 be added after the word market. That
16 was omitted due to a typographical error.

17 THE CHAIRMAN: When you say less than 40
18 reached the market, do you mean reached the market in 1958
19 or have ever reached the market?

20 MR. CONDER: Have ever reached the market,
21 yes sir.

22 Still the North American market for
23 pharmaceuticals grew. Upjohn built a new manufacturing
24 plant at Don Mills, Parke Davis built at Brockville and
25 Pfizer at Arnprior. Hoechst opened a Canadian company to
26 handle its then revolutionary oral anti-diabetic. Ortho
27 built at Don Mills, while Ciba and Sandoz moved to larger
28 facilities at Dorval. Wyeth at Windsor and BDH at Toronto
29 made extensive plant additions. Other established companies
30 followed suit, and still newer firms entered the Canadian



1 market, adding to employment and the Canadian economy.

2 Competition via discovery became stiff.

3 Formerly a leader in the corticosteroid market, Schering's
4 earnings on this continent suddenly dropped 23 per cent
5 in two years, when three other major competitors entered
6 the field. The price of penicillin on the world market
7 had become so low, that companies in Canada stopped
8 producing the raw substance. Merck was forced to close its
9 multi-million dollar penicillin, streptomycin and cortisone
10 plant outside Montreal, as a result of imports from low
11 cost countries, and some 400 Canadians were out of jobs.
12 As a result of competition at the manufacturers' level,
13 reserpine underwent a drastic drop in price within 18
14 months of its introduction to the Canadian market.

15 At the end of its second decade of rapid
16 development, the industry's phenomenal growth is levelling
17 off. Research is not producing as many new discoveries,
18 and the companies are placing more and more money into
19 research with the hope of breaking the barrier to still
20 another new molecular substance which, in turn, will
21 produce a further upsurge in growth. Allied to this is
22 the development of new drugs to compete with other drugs
23 which, although different in content, are used for the
24 same medical purpose.

25 Prices are continually being trimmed to
26 compete with different products in the same therapeutic
27 class, and with similar products held under compulsory or
28 voluntary license by competitors. Patents are no longer
29 a protective factor in marketing, although they still
30 remain the primary incentive to research. Average profit



1 margins are gradually narrowing, partly as a result of
2 industry growth and partly through increased operating
3 costs.

4 While retail prices remain relatively stable,
5 manufacturers are becoming more and more concerned with
6 the trend of their net earnings.

7 THE CHAIRMAN: Perhaps I might ask a
8 question in regard to the last paragraph you have just
9 been reading. "Prices are continually being trimmed to
10 compete with different products in the same therapeutic
11 class". Are you going to give us examples of these things?

12 MR. CONDER: Insofar as the pricing is
13 concerned sir we will have to fall back on the information
14 that may be available to this Commission through our
15 companies, or through Mr. MacLeod, insofar as the pricing
16 is concerned. However, it is recognized in our industry,
17 through examples which have occurred in the area of
18 competition, that companies have had to meet competition
19 by lowering prices.

20 For example, we mentioned earlier that
21 reserpine underwent a drastic drop in price within 18 months
22 of its introduction to the Canadian market. There was
23 competition by other companies entering the market with
24 much the same product.

25 THE CHAIRMAN: We had some discussion yester-
26 day, or the day before, about three companies making one
27 drug, each having their own trade name in which for a period
28 of about five or six years there was no change in price;
29 they were all selling at the same price and then in the
30 last year, 1960 and 61 there were at least two reductions in



1 in price so that we have some information to the effect
2 that in some cases at any rate there has been not a con-
3 tinual trimming, but rather a maintenance over a fairly
4 considerable period of time, in this particular case I
5 am referring to. Would you like to -- any information
6 you are able to give us -- I understand you are not in a
7 position to tell us what each of the companies has done
8 in detail?

9 MR. CONDER: No sir.

10 MR. WHITELEY: How do you relate the first
11 two sentences of those two paragraphs?

12 MR. CONDER: Would you care to clarify that?

13 MR. WHITELEY: The first paragraph says
14 "Prices are continually being trimmed to compete with
15 different products.." The first sentence in the second
16 paragraph says "While retail prices remain relatively stable.."
17 The prices at the manufacturers' level are being continually
18 trimmed. One would expect this to be reflected in changes
19 in prices at the retail level and therefore they would
20 also be continually being modified as well.

21 MR. HUME: Well Mr. Whiteley so I understand
22 the question, I think the first paragraph deals with the
23 price that the manufacturer sells at and as I read that
24 next sentence, I understand it may be the retail price at
25 which the goods are sold by the drug stores.

26 MR. WHITELEY: If they don't go along together
27 then the drug store margin is being continually modified.

28 MR. HUME: That may be sir. At the manu-
29 facturing level the prices are being trimmed, but at the
30 retail level they are remaining stable. This is the statement.



1 MR. WHITELEY: Also we have had evidence
2 that the price to the retail druggist is a percentage off
3 list and that he normally sells at close to list.

4 MR. HUME: I don't know as to that. I
5 understood the evidence was that the prices in drug stores
6 varied considerably. This was said in Montreal that there
7 was no uniformity. If there was uniformity there might be
8 some concern but one can go out and pay different prices
9 for the same prescription in a variety of drug stores which
10 would indicate that retail prices are not just a percentage
11 off list.

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1 THE CHAIRMAN: Maybe there is a conflict
2 of evidence on that.

3 MR. HUME: That may be.

4 THE CHAIRMAN: We have further evidence,
5 generally speaking, druggists do sell at or very close to
6 list price. There are some who don't. There are the
7 great majority that do. There was some evidence of that.
8 What he was getting at, of course, was do the manufacturers
9 reduce list price which would mean reduction to the retailer
10 and the retailer then continues to sell at the same price.
11 Take reserpine, a reduction has occurred over a period of
12 18 months, surely the retail druggists couldn't continue
13 to sell at the same price at the end of the 18 months they
14 were selling at the beginning.

15 MR. HUME: The Retail Druggists will come
16 on next. Perhaps they could clear it up.

17 MR. WHITELEY: You put forward a statement
18 of fact. There should be substantiation for your facts.

19 MR. CONDER: Probably this would clarify it.
20 I wouldn't say necessarily -- I am not a qualified witness
21 in the matter of prices per say, although I have heard
22 the same comment from companies concerning what has happened
23 when prices are brought down, the affect on the cost.
24 Certainly if companies do reduce price to the retail
25 pharmacist then it logically follows the retail pharmacist
26 would, in turn, reduce his price to the consumer because
27 as you point out it is invariably the suggested list price
28 which give the retailer his indication of what to charge.

29 Regarding these two statements I can
30 appreciate your point on it. We say in the second paragraph,



1 "While retail prices remain relatively stable" -- I believe
2 that would be the fact. From 1949 to 1956, as we say later
3 in this brief retail prices according to the Dominion
4 Bureau of Statistic consumer price index have increased
5 only 12.9% over an 11-year period. You can take that to
6 show retail prices have remained relatively stable.

7 Going back to this other paragraph: "Prices
8 are continually being trimmed to compete with different
9 products in the same therapeutic class" -- when you run
10 into a product coming out in the same therapeutic class
11 the companies must necessarily compete with new products
12 coming onto the market pricewise. The company would find
13 over a period of many years that its cost of equipment,
14 its cost of production, all its costs are rising continually
15 year after year and that if this cost were passed on into
16 the price of the product then the prices would have been
17 increased considerably more than 12.9%. We have found,
18 we would say we have evidence which does show prices are
19 continually being trimmed to compete with different products
20 in the same therapeutic class. We still say retail prices
21 have remained relatively stable.

22 MR. WHITELEY: What do you mean by "trimmed"?
23 Do you mean prices are continually being reduced, is that
24 what you mean?

25 MR. CONDER: Continually reviewed and trimmed
26 wherever possible to avoid passing on ...

27 MR. WHITELEY: By trimmed do you mean the
28 prices are actually changed or just stay where they are by cost
29 saving in the manufacturing field?

30 MR. CONDER: Yes, and in some cases -- the



1 12.9 is necessarily an average and that you will find over
2 that 11-year period that new products have come onto the
3 market which are more costly by virtue of manufacture,
4 such as the biologicals which are more costly to produce.
5 This would tend to push up the prices for the average where-
6 as companies who have had products on the market for some
7 time would tend to level off or actually reduce prices.

8 MR. WHITELEY: It seems to me you are
9 modifying the meaning of that sentence. As it is now prices
10 are being trimmed, you are suggesting that the prices are
11 being changed and trimmed, being changed downward.

12 MR. CONDER: They could in some cases.

13 MR. WHITELEY: Continually, this thing is
14 happening every month.

15 MR. CONDER: I would presume, sir, that all
16 companies are continually reviewing their prices to see
17 whether they can continue to compete on the market with
18 other products which are coming onto it.

19 MR. WHITELEY: That is the real meaning of
20 the sentence rather than what is written here?

21 MR. CONDER: That is correct, yes.

22 THE CHAIRMAN: The next sentence in that
23 paragraph was interesting to me, "Patents are no longer a
24 protective factor in marketing although they still remain
25 the primary incentive to research". Do you mean the patent
26 gives no protection on the market?

27 MR. CONDER: They are no longer the protective
28 factor on the market as they were at one time or are in
29 some countries such as the United States. We do go into
30 that under the section Patents in considerable detail.



1 THE CHAIRMAN: On the face of that, the
2 first conclusion -- I would wonder if the patent isn't the
3 protective factor on the market why anybody, but is
4 important in research, if they are not going to get some
5 benefit out of the patent there isn't any reason for them
6 going after it.

7 MR. CONDER: That is correct. Some of the
8 companies, as you probably realize from the testimony yesterday
9 I believe that the entire subject of patents should be
10 reviewed, according to these companies. It is not necessarily
11 the opinion of our Association, and that the protective
12 factor in a patent is not as strong as it should be in view
13 of the cost of research.

14 THE CHAIRMAN: In view of the cost of
15 research. I thought perhaps you meant in view of certain
16 types of competition which makes it difficult for them to
17 benefit from the patent.

18 MR. CONDER: Yes.

19 THE CHAIRMAN: There was some evidence on
20 that.

21 MR. CONDER: We have covered that in great
22 detail. All the points contained in this introduction are
23 enlarged on later in the brief.

24 THE CHAIRMAN: This was an interesting
25 sentence to me.

26 MR. CONDER: Large companies presently doing
27 at least 94 per cent of their manufacturing in Canada are
28 continually examining the potential for the other six per
29 cent.

30 With the swinging of the competitive pendulum,



1 one company recently announced the construction of a multi-
2 million dollar primary antibiotic plant in Southern Ontario.
3 The chemical industry, suppliers of raw materials for the
4 manufacture of pharmaceuticals, is also carefully watching
5 the population growth which forecasts markets sufficient
6 in size to warrant establishing primary producing plants
7 in Canada.

8 Provided Canada continues to grow and
9 prosper, and the industry is permitted to expand through
10 logical development, the future is bright. But there is
11 an overcast on the horizon. For there are pressures in
12 favour of importing drugs from abroad, which could result
13 in removing the incentive for domestic manufacturing and
14 the loss of employment to thousands of Canadians.

15 During the first six months of 1961, the
16 cumulative monthly sales of pharmaceuticals in Canada was
17 down 11 per cent over the previous year. Sales of
18 stataratics, which represent about six per cent of the total
19 market were off six per cent while antibiotic sales,
20 representing about 10 per cent of the market, were down
21 12 per cent during this six month period.

22 THE CHAIRMAN: Those are dollar figures you
23 are referring to?

24 MR. CONDER: Yes sir.

25 There is no doubt that our pharmaceutical
26 manufacturers can cope with market trends and narrowing
27 profits through competitive efficiencies, and so continue
28 to provide for Canadians the finest medication available at
29 a reasonable price well within the average Canadian's
30 purchasing ability. But it can only do so if its future



1 remains unfettered, and the decisions relating to this
2 future are based on an accurate understanding of the
3 industry's accomplishments and role in the economy of the
4 nation.

5 To present the facts as they apply to pharma-
6 ceutical manufacturing, we will deal first with the
7 industry itself.

8 THE INDUSTRY IN GENERAL

9 While the green book uses Dominion Bureau
10 of Statistics' figures for manufacturing for the years
11 1957 and 1958, against results of its own survey for the
12 year 1959, DBS has since published its annual report for
13 the year 1959.

14 According to the 1959 report, the industry
15 comprised 188 companies engaged in manufacturing both
16 ethical pharmaceuticals and proprietary medicines, a decline
17 of eight companies from the previous year.

18 Many of these 188 firms are small regional
19 concerns, while others manufacture proprietary preparations
20 exclusively. It has been estimated, however, that about
21 70 of them are multi-line ethical pharmaceutical manu-
22 facturers, as we understand the term, about 75 are multi-
23 line proprietary manufacturers, while the balance are
24 agents, wholesalers and retailers who also manufacture
25 some medicinals plus packaging concerns and other suppliers.
26 Furthermore, this list does not include two major companies
27 which manufacture ethical pharmaceuticals in Canada, and
28 which are members of our Association.

29 The 188 companies listed by DBS shipped
30 during 1959 a total of \$164,733,036 worth of pharmaceuticals,



1 proprietaries and certain other lines such as toiletries
2 which are a secondary part of their business. It shows
3 the actual production in Canada of medicinals, pharma-
4 ceuticals and biologicals for 1959 at \$154,334,000 plus
5 imports of \$32,428,000, for a total of \$186,762,000. It
6 is further estimated that proprietary medicines account
7 for approximately 22 per cent of this total which means
8 that Canadian manufacturers and importers supplied in the
9 neighborhood of \$145,674,360 worth of ethical pharmacueti-
10 cals and biologicals for both human and veterinary use
11 in 1959.

12 According to DBS, the gross selling value
13 of medicinal and pharmaceutical products shipped by manu-
14 facturers in Canada increased 6.3 per cent from 1958 to
15 1959. Similarly, imports reached an all-time high in 1959
16 with a 10.9 per cent increase over 1958. Exports declined
17 29.3 per cent from \$9,560,000 in 1958 to \$6,758,000 during
18 the same period.

19 Based on the shipment figure of \$186,762,000,
20 imports were about 17 per cent of the total for the year.
21 This is significant in light of the various statements in
22 the green book which have created, and we believe un-
23 intentionally, the misconception that the large percentage
24 of ethical pharmaceuticals are imported.

25 If we discount the importers, and there are
26 a large number of these in Canada, the percentage of im-
27 ports by ethical manufacturers are extremely low in relation
28 to Canadian production.

29 THE CHAIRMAN: Just to be clear again when
30 you are speaking of the percentage of imports compared to



1 the percentage manufactured in Canada are you referring
2 only to the finished manufactured article in dosage form
3 as being imported?

4 MR. CONDER: Yes sir.

5 THE CHAIRMAN: This wouldn't have reference
6 to bulk shipments that are brought in and manufactured in
7 dosage form.

8 MR. CONDER: I believe it does include
9 bulk shipments because the Dominion Bureau of Statistics
10 mentions bulk in certain of its classifications.

11 THE CHAIRMAN: It would be imports on
12 refined drugs?

13 MR. CONDER: That is correct, yes.

14 MR. WHITELEY: What about the 94% of the
15 28 manufacturers?

16 MR. CONDER: On these 28, I believe you
17 will find the majority of the 28 manufacturers each do
18 have very heavy manufacturing facilities in this country.
19 A company which is an importer, of course adding his
20 figures into the total would bring down this percentage
21 considerably.

2 22 MR. WHITELEY: I was wondering where the
23 line was drawn whether the 28 import in bulk and then do
24 the packaging in Canada or the tableting in Canada?

25 MR. CONDER: This would be manufacturing
26 as we consider the term as we will go into. We consider
27 manufacturing of the product into the dosage form is
28 manufacturing as such. You might have a combined product
29 with three or four different ingredients. These ingredients
30 could be imported into the country and the Canadian manu-



1 facturer then would have his raw materials and he would
2 take the three or four parts and combine them into the
3 final product in dosage form and then package that product,
4 and ship it out.

5 MR. WHITELEY: There is a possibility some
6 of these figures are duplicated?

7 MR. CONDER: In what respect?

8 MR. WHITELEY: Some of the import reappear
9 in the output of the Canadian manufacturers.

10 MR. CONDER: You are speaking of this 17%?

11 MR. WHITELEY: You are saying these import
12 figures might include both bulk imports as well as dosage
13 imports?

14 MR. CONDER: I would imagine that in some
15 of these things there would be a certain amount of overlap
16 on bulk shipping. I would presume that the Dominion Bureau
17 of Statistics in Ottawa in getting these figures would have
18 a certain amount of overlap. It is mentioned in their
19 publication when it is published each year that in the
20 medicinal and pharmaceutical industries it includes some
21 toiletries, which obviously don't come into pharmaceutical
22 and medicinal preparations. There could conceivably be
23 some overlap.

24 THE CHAIRMAN: You haven't any data which
25 you could advise us to the extent of the overlap. I was
26 thinking it might be a large overlap on certain types of
27 drugs brought in, say, in bulk powder form -- these are in
28 the imports, and then they are made into tablets, whether
29 alone or in composition with other powders or ingredients
30 and that would go into manufacturing. You might have a



1 large degree of overlap.

2 MR. CONDER: Yes, that is correct.

3 THE CHAIRMAN: I wonder if you could add
4 anything.

5 MR. CONDER: I believe the Dominion Bureau
6 of Statistics shows in the import of chemical lines --
7 they are under their chemical industrial classification.
8 There is a dividing line there. Unfortunately I am not
9 qualified to explain what it might be.

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1 This is further borne out by a survey of
2 28 companies which we undertook in 1960, indicating clearly
3 that these firms manufacture in Canada 94 per cent of their
4 products, and import only six per cent.

5 THE CHAIRMAN: I think you indicated those
6 were among the larger manufacturing companies.

7 MR. CONDER: Yes sir there would probably
8 be a couple of smaller companies in there, because some
9 of the smaller companies do manufacture extensively as
10 well, but these would be primarily manufacturing companies
11 as well.

12 MR. WHITELEY: In one survey you say --
13 could you define this import aspect?

14 MR. CONDER: In what respect, sir?

15 MR. WHITELEY: You say you want to know what
16 the import in finished form was. What would be an import?

17 MR. CONDER: Do you mean the six per cent
18 figure or the actual manufacturing?

19 MR. WHITELEY: Yes.

20 MR. CONDER: Well, the term of reference is
21 to actual manufacturing in Canada of a product, where the
22 company takes the ingredient or a group of ingredients and
23 compounds those ingredients into a finished product and
24 has the finished product. That is manufacturing. In other
25 words, this compounding constitutes manufacturing in our
26 industry.

27 When ingredients, active or inactive, are
28 imported into the country not in final dosage form, then
29 those are raw materials to our industry. We have always
30 considered it as such.



1 MR. WHITELEY: So when you are referring to
2 imports of six per cent, you are referring to imports in
3 finished form?

4 MR. CONDER: Yes sir.

5 Nor was there any significant difference
6 according to financial control. The wholly-owned Canadian
7 firms manufacture 98 per cent of their products in Canada;
8 the U.S. subsidiaries, 92 per cent; and the European
9 subsidiaries, 94 per cent.

10 The firms covered in this survey were manu-
11 facturers and not merely distributing companies. In
12 another survey of 40 firms, which included non-manufacturing
13 members, we found that 81.5 per cent of the total sales
14 volume was manufactured and packaged in Canada, 11.8 per
15 cent was made outside Canada but packaged here, while 6.7
16 per cent was manufactured and packaged in other countries.

17 In another example, the green book refers,
18 on page 226, to the manufacture of "basic" antibiotics
19 and ataractics and that "it is clear that most are imported
20 into Canada." If this refers to the raw materials used in
21 manufacturing, then this is correct. However, it is
22 interesting to note that while the DBS annual report does
23 not separate ataractics from its total volume, it does
24 show that in 1959, \$20,813,894 worth of antibiotic prepara-
25 tions were "made in Canada," a figure which cannot be far
26 from the total Canadian market even though imports are
27 not included.

28 MR. WHITELEY: Before you leave this, was
29 the same survey form used for these two groups of companies?

30 MR. CONDER: Much the same. We did -- I



1 would have to check the terms of reference on that, Mr.
2 Whiteley.

3 We handled through one accounting firm this
4 first one, and this second one was made as the result of
5 a Clarkson-Gordon survey of our companies.

6 MR. WHITELEY: I notice on the second one
7 you have got a distinction between manufacturing packaged
8 in Canada and manufacturing packaged outside of Canada.

9 MR. CONDER: Yes.

10 MR. WHITELEY: And then, thirdly, manufactured
11 and packaged in other countries.

12 MR. CONDER: Well, these 40 firms were
13 part of an overall survey which we undertook of all the
14 member companies, and we do have some member companies
15 which don't manufacture in Canada.

16 MR. WHITELEY: I was wondering, in the first
17 group where this second class fell. In other words, the
18 11.8 per cent made outside Canada but packaged here.

19 MR. CONDER: That would be in the case where
20 a firm would have its packaging facilities in Canada, which
21 would probably import in bulk in finished form and have it
22 packaged here.

23 MR. WHITELEY: But where would they fall in
24 the first group of companies?

25 MR. CONDER: I honestly don't know because
26 that is not manufacturing according to our definition.
27 Packaging is not manufacturing. It is the compounding of
28 the product which is manufacturing.

29 MR. HUME: Perhaps it might be helpful if
30 I cleared this point up, Mr. Chairman. The first survey was



1 the preliminary survey made when you were gathering material
2 for submission to the Ontario Select Committee before the
3 Green Book was published.

4 MR. CONDER: That is correct. That was last
5 year.

6 MR. HUME: And the second survey was a more
7 complete one because of the fact the Association was
8 intending to make presentation to this Commission as well
9 as to the Ontario Select Committee, is that right?

10 MR. CONDER: That is correct, yes.

11 Confusion in this respect has undoubtedly
12 been created by the various references to drugs, pharma-
13 ceuticals, chemicals, basic drugs, dosage forms, and
14 other similar wording. When the term drugs or pharmaceuti-
15 cals is used in this industry it refers to dosage forms
16 or the final product prescribed by the doctor and dispensed
17 by the pharmacist. The gross selling value of products at
18 the manufacturing plant, used by DBS, refers to products in
19 dosage form and not to raw materials.

20 Pharmaceutical chemicals are raw materials to
21 this industry. In a few cases, a chemical may be a drug
22 but not all drugs are chemicals. Raw chemicals or active
23 ingredients may be imported, but where the actual compounding
24 into dosage form is done here then this compounding con-
25 stitutes manufacturing.

26 It is an unfortunate fact that a large
27 percentage of the raw materials used in this industry must
28 be imported. The market for pharmaceuticals in Canada
29 is not yet large enough to support a complete raw materials
30 industry. The volume in dosage form is still too low to



1 permit effective competition in many raw materials with
2 suppliers in large volume markets such as the U.S., U.K.,
3 Italy or Japan, to name but a few. The time will come when
4 it will be economical for our chemical industry to
5 establish a complete raw materials division for our
6 industry. In the meantime, Canadian pharmaceutical manu-
7 facturers must import many of their raw materials so that
8 they can continue to manufacture drugs and place them on
9 the market at the lowest possible price.

10 As an Association, we are primarily interested
11 in manufacturers, although we do have some members which
12 are importing subsidiaries. Nevertheless, 83 per cent
13 of the pharmaceuticals sold in Canada are manufactured
14 here and many of our member companies are making more than
15 90 per cent of their products in this country.

16 To iterate, when reference is made to drugs
17 and pharmaceuticals, it covers the end product and not the
18 raw materials which go into that product.

19 In reference to Canadian manufacturing, DBS
20 shows that our manufacturing plants employed 8,146 Canadians
21 in 1959, at a total wage bill of \$31,133,539. That was
22 two years ago. Considering the manufacturers not included
23 in this total and the many importers who maintain packaging
24 operations here, it is estimated that total employment in
25 this industry is now in the neighborhood of 10,000 and that
26 salaries and wages paid to these employees is at least
27 \$39,000,000.

28 Attached to this submission, under Appendix
29 C, is a copy of the economic report on our industry which
30 Dr. Brian Dixon of Queen's University prepared in 1960.



1 This report points out that wage payments per worker in
2 pharmaceutical manufacturing have risen more rapidly than
3 for the manufacturing group as a whole, which reflects the
4 comparatively large proportion of skilled personnel
5 required in this industry.

6 It is significant that during the past 12
7 years, salaries and wages have increased by more than
8 \$15,000,000. Furthermore, the employees represent some
9 10,000 households and, according to a formula developed by
10 the CNR research department, they account for a total of
11 about 22,000 jobs as a result of their bearing on con-
12 struction, transportation, communications, finance,
13 insurance, utilities and other services. Granted, the
14 industry is a small one in comparison to some of our large
15 durable goods industries, but there can be no doubt that
16 pharmaceutical manufacturing is making a worthwhile
17 contribution to employment and the national economy.

18 The DBS annual report also indicates that
19 no mere handful of companies controls the pharmaceutical
20 and medicinal manufacturing business in Canada. In 1959,
21 50 firms accounted for 89 per cent of the business, as
22 compared to 53 companies representing 90 per cent in 1958.
23 The remainder of the business was shared by 138 firms in
24 1959 as against 143 firms in 1958.

25 This ratio has remained fairly constant
26 since 1955, and the status quo plus the large number of
27 small companies in the industry is further evidence that
28 there is no monopoly of the pharmaceutical market in Canada.
29 Also, these low-volume firms while small in relation to the
30 national companies, are often regional in character with



1 sales volumes in their respective areas often higher than
2 those of the large firms.

3 As we have shown, sales of antibiotics and
4 ataractics were down an average of about nine per cent
5 during the first six months of 1961. This is a significant
6 decline for any market, and is indicative of the need for
7 product diversification in pharmaceutical manufacturing.
8 The green book bases many of its conclusions on the results
9 of the antibiotic and ataractic market, which only
10 represents about 16 per cent of the total market. Anti-
11 biotics and ataractics are not necessarily typical of this
12 market. If anything, they are atypical, and any attempt
13 to pre-judge pharmaceutical manufacturing on the basis
14 of these two products alone is bound to produce grievous
15 errors.

16 To retain its position in the Canadian
17 market, a company must spread its cost over many products.
18 It could not take the chance of limiting itself to one
19 major field such as ataractics or antibiotics.

20 As is noticeable from the overall decline
21 in antibiotics and ataractics this year, companies are
22 constantly faced with a fluctuating rise and decline in
23 sales from product to product. A company may conceivably
24 find itself in first or second place on antibiotic sales
25 this year. Next year, it might be in fifth or sixth place.
26 If a competitor brings out an improved product in the same
27 therapeutic class, its sales are bound to affect those of
28 the first company. Accordingly, the first company must
29 have some other major product to help carry the loss to its
30 antibiotic sales. Plummeting sales of a large-volume



1 product can materially change a company's entire financial
2 picture.

3 For this very reason, it is not practical
4 to base a company's entire operations on on one or two
5 products, such as antibiotics or ataractics. We must base
6 our finding on the company's overall operations, and this
7 is equally true at the industry level. This was borne
8 out in the recent survey referred to earlier. Thirty-five
9 companies indicated the following:

10 10 make both antibiotics and ataractics;

11 12 make antibiotics but no ataractics;

12 5 make ataractics but no antibiotics;

13 8 make neither antibiotics nor ataractics.

14 Thus, 20 of these 35 firms make no ataractics,
15 while 13 make no antibiotics, and these are all major
16 companies in the inudstry.

17 Allied to this product diversification, is
18 the fact that many pharmaceutical manufacturers carry
19 "public service" products on which they actually lose
20 money or break even on cost. Some of these drugs are
21 actually given away free. These are largely products
22 discovered in pharmaceutical laboratories which have a
23 limited use in that they are often for rare diseases or
24 ailments.

25 In many cases these "public service" products
26 are the result of extensive research, but for a variety of
27 reasons have a small demand. Aldosterone is an excellent
28 example. Used to combat diminished or absent adrenal
29 function, this mineralocorticoid was isolated and
30 synthesized by Ciba. While of major physiological importance,



1 it has yet a limited therapeutic use.

2 Few Canadians have cause to fear venomous
3 snakes in this country. Yet the occasional near fatality
4 does occur, and it is for this reason that Wyeth maintains
5 a stock of Antivenin, the anti-snake bit serum. Roche,
6 on the other hand, produces a chemotherapeutic agent
7 called 5 FU. Administered in the treatment of certain
8 cancers, it is given free to qualified clinicians.

9 Warner-Chilcott did considerable research
10 on Releasin, only to find that it is extremely difficult
11 and costly to manufacture. Initially used in threatened
12 abortion, it has not been found helpful in alleviating
13 scleroderma, a rare disease causing hardening of the skin
14 and for which there is no known cure. The company loses
15 money every time it makes a sale of this product.

16 Mead Johnson's Lofenalac is truly a life-
17 saving boon to sufferers of phenylketonuria. This is a
18 rare disease of children which, if untreated, will eventually
19 cause permanent and fatal damage to the brain. Fortunately
20 this disease can be easily detected and, if determined in
21 the early stage, Lofenalac will actually prevent that
22 brain damage, permitting the child and later the adult to
23 live a normal life. This is the only product of its kind
24 available in Canada. Yet Mead Johnson makes it available
25 at cost, taking no profit whatever on the product.

26 While products such as these are not
27 commercially profitable, companies keep them in stock for
28 humanitarian reasons. In most cases, the use is so limited
29 that the so-called prestige value bears no relationship to
30 the cost involved.



/dpw

1 A recent survey of 39 companies indicated
2 that 22 of these firms carry products of this type.
3 During 1960, these 22 manufacturers supplied a total of
4 112 public service products at a total volume of about
5 \$400,000 for an average of some \$3,571 per product for
6 the year. One company with 10 such products reported
7 that its individual product sales ranged from 19 to 7,540
8 packages during the 12-month period.

9 Other factors must also be considered when
10 judging the efficiency and effectiveness of this industry,
11 such as the guaranteed sales policy which is almost unique
12 to pharmaceutical manufacturing. This is where the company
13 agrees to take back for credit or exchange, products which
14 for some reason or other are not used or sold. It will be
15 appreciated that pharmaceuticals are vitally important to
16 the health of the patient, and it is essential that the
17 supplies on retail shelves be maintained in peak condition.
18 If it were not a policy of manufacturers to accept returned
19 goods for credit, retailers and wholesalers would be forced
20 to either refuse to maintain adequate stocks, or resort to
21 higher prices to compensate for the additional cost
22 involved.

23 As practices appeared to vary from company
24 to company on this subject, we conducted a survey of member
25 companies to provide a consensus for this submission. Of
26 39 companies which replied:

- 27 1. 38 permit the return of goods from
28 hospitals, for full credit.
29 1 accepts returns from hospitals for
30 partial credit.



1 2. 35 permit the return of goods from
2 government departments for full credit,
3 although one qualified this by adding
4 "if not on contract".

5 1 stated "provincial hospitals only".
6 2 accept such returns for partial credit.

7 3. 39 permit the return of goods from
8 wholesalers for full credit.

9 4. 38 permit the return of goods from
10 retailers for full credit.

11 1 accepts such returns for partial credit.

12 One company added the note that "our
13 returned goods result in about 4 per cent of our sales in
14 any calendar year". Another company stated that partial
15 credit may be given instead of full credit, depending on
16 age and condition of the material returned.

17 Regarding retailers, most companies will
18 accept back unopened packages regardless of the condition
19 of the package, but the majority will not accept returns
20 for full credit where the package has been opened.

21 Thirty-six of the 39 accept returns of
22 obsolete products when they have been replaced by newer
23 products. Twenty do not specify a time limit within which
24 the product must be returned for credit, but 19 do specify
25 a time limit which in most cases is considered liberal.
26 This, of course, would depend in some cases upon the
27 number of undated products on the company's list. Some
28 companies authorize their detailmen to take back an
29 opened package and replace it with a product of approxi-
30 mately the same value, but this practice is not prevalent.



1 We also asked the companies what they do
2 with returned goods and 35 replied that they generally
3 destroy such returns. However, many companies will attempt
4 to salvage returns provided that the material is not dated,
5 is of recent manufacture, and the container is only
6 damaged or soiled. This applies primarily to tablets, and
7 such returns must first be approved by the quality control
8 laboratory.

9 In respect to marketing, one witness before
10 this commission referred to companies insisting that non-
11 prescription products be sold only on prescription. This
12 point subsequently has arisen many times during the
13 Commission's cross-examination of witnesses. Accordingly,
14 we asked our companies this question: "Have you at any
15 time insisted that non-prescription items be sold only on
16 prescription at the retail level?". The 39 companies
17 which replied to this survey all stated "no".

18 One company qualified its negative reply, by
19 first stating that it has never insisted that this be done,
20 but adding that it may have dissuaded a retail pharmacist
21 from selling a non-prescription product over the counter:
22 "As an example, if we were asked by a retail pharmacist
23 if one of our antihypertensive agents could be sold over-
24 the-counter, our answer would be that it could be sold
25 legally. But since it is a potent substance which is used
26 in the treatment of a serious ailment, we would suggest
27 that in the patient's interest, it would be preferable that
28 a physician be consulted".

29 Another company followed this example in
30 1956 during introduction of a new and highly potent



1 ataractic of the perphenazine family. In view of extra-
2 pyramidal symptoms involved in this drug, the dosage had
3 to be carefully adjusted to the patient according to
4 recommended maximums. This company felt that the drug
5 should be used only under a physician's supervision, but
6 ataractics were not officially classified as prescription
7 drugs at that time. For this reason, the company discour-
8 aged over-the-counter sale of this product until it and
9 other ataractics were eventually placed on the prescrip-
10 tion list.

11 The final decision was, of course, left to
12 the pharmacist's discretion, and it is generally accepted
13 that our companies do not and can not insist that non-
14 prescription items be sold on prescription.

15 THE CHAIRMAN: Mr. Conder, it is half-past-
16 twelve. The next part you will deal with will take a
17 little while?

18 MR. CONDER: Yes, sir.

19 THE CHAIRMAN: I think it might be a good
20 place to adjourn for lunch. Resume at 2 o'clock.

21

22 --- Luncheon adjournment.

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TT/dpw

1 --- On resuming at 2.05 p.m.

2 MR. HUME: Mr. Conder, you were at the top
3 of page 16. If you would like to carry on, please.

4 MR. CONDER: To assist the Commission in its
5 deliberations, we are including on the following three
6 pages tables showing a breakdown of the average sales
7 dollar of 40 companies for the year 1960, and an analysis
8 of the sales dollar in percentages for the years 1958,
9 1959, and 1960.

10 It will be noticed that profits after taxes
11 in 1960 were 5.5¢ of the sales dollar, as compared to
12 4.4¢ for all manufacturing industry. Compare this 5.5¢
13 profit with the 11.7¢ which was paid out in excise, sales
14 and income taxes for the year.

15 More than one-quarter of the total sales
16 dollar, or 26.2¢ went towards wages, salaries and employee
17 benefits, while materials used in manufacturing accounted
18 for 28.7¢. Comparing expenses to profits, it cost our
19 pharmaceutical manufacturers 94.5¢ for every dollar's worth
20 of merchandise sold in 1960.

21 As will be seen from the table covering
22 percentages for the three-year period, the portion of the
23 sales dollar allocated to wages and salaries increased
24 from 1958 to 1960, while that for all manufacturing
25 decreased. In line with the national average, the cost of
26 materials used in manufacturing has steadily declined.
27 Excise and sales taxes, on the other hand, have steadily
28 risen. The ratio of taxes on income to profit has gradually
29 narrowed to the point where it is now even.

30 While the breakdown of the sales dollar



1 naturally varies from industry to industry, it is signifi-
2 cant from the Canadian Manufacturers' Association's
3 comparison, that pharmaceutical manufacturing is not out
4 of line with the average for all manufacturing. The
5 comparisons for the year 1960 indicate that our cost of
6 materials is not as high as that for all industry. While
7 our profit after taxes is 1.1, if you would merely, sir,
8 delete "per cent" there, higher than the national average,
9 it is significant that a greater percentage of our sales
10 dollar goes towards wages and salaries, and taxes.

11 MR. HUME: May I request that the next three
12 pages be taken into the record as if they were read to
13 save repetition of a lot of numbers?

14 THE CHAIRMAN: Yes, unless there is some
15 point he wishes to bring out.

16 MR. HUME: Yes, Mr. Conder may want to make
17 some comment, but I would ask that instead of reading
18 those three pages, they be taken as read.

19 THE CHAIRMAN: There may be some questions
20 arise out of them. It will not be necessary to read it,
21 but there may be some things you would like to comment
22 about in connection with the next three pages, and ques-
23 tions may arise in the course of that.

24 MR. CONDER: On pages 17 and 18 we have the
25 result of an annual statistical survey for the year 1960,
26 which is based on a survey of 40 pharmaceutical manufac-
27 turing companies, undertaken on behalf of our Association
28 by Clarkson, Gordon and Company, Toronto.

29 You will notice that the explanatory items
30 such as net sales, wages and salaries, employee benefits,



1 materials, etc., conform with that used for the Canadian
2 Manufacturers' Association annual survey. We give here,
3 sir, the dollar value, and then the percentage of that
4 dollar value in relation to total net sales and to total
5 expenditures.

6 THE CHAIRMAN: In relation to total income?

7 MR. CONDER: Yes, in relation to total
8 income.

9 THE CHAIRMAN: This is a question that
10 occurs to me; there is, of course, a very valid basis
11 for working out your return on the basis of the percentage
12 of the sales dollar which is net profit, and some other
13 point of view such as investment point of view I would
14 think would be more relevant to net percentage of profit
15 in relation to invested capital. That may be quite diffe-
16 rent. I wonder if you had any study made along that line,
17 or could tell us what the comparison would be in any sort
18 of way?

19 What I had in mind, sometimes an industry
20 will sell goods with a very rapid turnover, and in the
21 course of a year their total sales may be several times
22 their invested capital.

23 MR. CONDER: Yes.

24 THE CHAIRMAN: Whereas in another industry
25 their sales may be less than the invested capital in one
26 year. Now, 5% net profit on sales in the case where you
27 have sales less than your invested capital, your total
28 sales, wouldn't be a high return, but if you sold ten
29 times your invested capital in one year and had 5% on
30 sales, you would have a pretty good position from the



1 point of view of your shareholders.

2 MR. CONDER: Yes, we have used a percent
3 factor, percentage based on the sales dollar after taxes
4 for two reasons. The first reason is that it is a denomi-
5 nator which we have used in our industry for some years
6 now, and one which the Canadian Manufacturers' Association
7 and other secondary industries have used in realizing
8 valuable information. We want to use it firstly to know
9 how does this industry stack up with the manufacturing
10 industry generally, and we were able to do this by
11 following the Canadian Manufacturers' Association survey,
12 and so relate the figures. That is our only reason for
13 including it in this form.

14 This point has been brought up many times
15 about basing your money on your capital invested, basing
16 your percentage of profit on capital investment, and we
17 have had quite a few different opinions on it. Some
18 people have said you run into this particular problem,
19 for example, where a company which is a pure importing
20 company would have an almost fabulous percentage of profit
21 if it were based on the capital employed in the business
22 compared ---

23 THE CHAIRMAN: Pretty profitable company.

24 MR. CONDER: Pretty profitable company -
25 compared to one which has heavy manufacturing facilities.

26 THE CHAIRMAN: It depends on the rapidity
27 of turnover of the product.

28 MR. HUME: May I make this comment: an
29 importing company is not necessarily a profitable company
30 because it doesn't have a large capital investment. It



1 might have to pay -- it has to pay something to the manu-
2 facturer, and therefore the cost of the material would be
3 that much. To that extent I respectfully submit percen-
4 tage on sales dollar is valid even with an importing
5 company the way we have done it, whereas on the straight
6 cost of capital investment, the company may not be profi-
7 table, but on your basis it would be.

8 THE CHAIRMAN: I am not saying it is not a
9 valid basis for comparison. I am saying if you have an
10 importing company with a fabulous return on its invested
11 capital, it is still a good company to have your money in.

12 MR. HUME: Not if it costs all but 1% of its
13 return to buy the product which it imports. That is my
14 point.

15 MR. WHITELEY: I can't follow you.

16 MR. HUME: If you have a company in Canada
17 without a large capital investment who was making on the
18 basis of what I understand is the Chairman's criteria, a
19 very large percentage on the basis of investment capital,
20 it is not necessarily a profitable company because where
21 it may sell the product for a dollar, it may cost 99 cents
22 to import it. It still hasn't capital investment, but its
23 profit is 1%.

24 THE CHAIRMAN: It must have some capital.

25 MR. HUME: I assume it has warehouses or
26 some minor capital.

27 THE CHAIRMAN: It must have some working
28 capital.

29 MR. HUME: Perhaps it can borrow from the
30 bank. Perhaps it has a subsidiary which gets guarantees



1 from other places. I am only trying to suggest - I am
2 not criticizing for one moment the suggestion - but I am
3 trying to point out merely investment capital is not
4 necessarily I respectfully submit as good a basis as the
5 one which the Canadian Manufacturers' Association has
6 developed, because investment capital in relation to sale
7 is only important if you know what you paid for your pro-
8 duct. That is my only point, sir.

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- 17 -

RESULTS OF THE STATISTICAL SURVEY FOR THE YEAR 1960

The following is the result of a survey of 40 pharmaceutical manufacturing companies, undertaken on behalf of C.P.M.A. by Clarkson Gordon & Company, Toronto. 11/

	<u>Dollar Value</u>	<u>Percentage</u>
1. NET SALES (That is, gross sales including sales tax where sales are made tax included, less returns and allowances):		
a. HUMAN PHARMACEUTICALS (Incl. all vitamins and O-T-C pharmaceuticals):	\$107,929,000	84.2%
b. VETERINARY PHARMACEUTICALS:	2,029,000	1.6%
c. PROPRIETARY MEDICINES (Patent medicines but not O-T-C pharmaceuticals):	826,000	0.7%
d. CHEMICALS:	7,346,000	5.7%
e. OTHER PRODUCTS (not listed above):	8,237,000	6.4%
TOTAL NET SALES:	126,367,000	98.6%
f. NOTE: participants reported that they manufactured \$3,021,000 worth of merchandise for other C.P.M.A. members, including \$2,791,000 of human pharmaceuticals.		
g. OTHER INCOME:	1,836,000	1.4%
TOTAL INCOME: (Comprising a, b, c, d, e and g, and including sales tax):	<u>\$128,203,000</u>	<u>100.0%</u>
2. WAGES AND SALARIES (All wages and salaries including management salaries, directors' fees, payments to employees for holidays and in connection with profit sharing or production incentive plans, unless such payments are distributed only upon retirement of employee or some similar basis, in which case they are included in 3.):	31,183,000	24.3%

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3. EMPLOYEE BENEFITS (Payments to pension plans, group life, sickness or hospitalization insurance, workmen's compensation, unemployment insurance, medical services, cafeterias, welfare funds, 25-year clubs, etc.):	2,396,000	1.9%
4. MATERIALS (Including raw materials, finished and semi-finished materials, purchased for resale, materials consumed in processing operations, and packaging and shipping materials, but not plant supplies which are included in 6.):	36,765,000	28.7%
5. EXCISE AND SALES TAXES (Include in 1. above, remitted or to be remitted to Dominion and other governments):	8,021,000	6.2%
6. OTHER EXPENSES (Including plant supplies, power, water, municipal taxes, maintenance, repairs to buildings, machinery and equipment (not including salaries and wages or employee benefits included in 3. above), office, administrative and selling expenses not included above, including charitable and interest expense):	33,613,000	26.2%
7. DEPRECIATION:	2,157,000	1.7%
8. TAXES ON INCOME (Dominion and provincial taxes on income):	7,063,000	5.5%
9. PROFIT (Including profits distributed and amount retained in the business):	7,005,000	5.5%
TOTAL (Comprising 2 to 9 inclusive):	<u>\$128,203,000</u>	<u>100.0%</u>
10. NUMBER OF EMPLOYEES (Average over 12-month period of fiscal year):	5,950	
11. TOTAL NET WORTH (Capital stock - preferred common etc. - and total retained earnings - surplus and reserves):	\$57,800,000	

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ANALYSIS OF THE SALES DOLLAR IN PERCENTAGES
FOR 1958, 1959 AND 1960

The following shows the breakdown of the sales dollar in percentages for pharmaceutical manufacturing companies in the years 1958, 1959 and 1960. The number of companies involved and the accounting firms retained to compile returns to these surveys are as follows:

<u>YEAR</u>	<u>NO. FIRMS REPLYING</u>	<u>SURVEY HANDLED BY</u>
1958	28	John S. Entwistle & Co., Toronto.
1959	43 <u>12/</u>	Henry Glover & Co., Toronto.
1960	40 <u>13/</u>	Clarkson Gordon & Co., Toronto.

The percentage figures in brackets below are the results of the Canadian Manufacturers Association survey for all manufacturing industry in Canada, and are included for comparison. For further information on headings see details shown under headings of the dollar volume tabulations on the preceding pages.

	<u>1958</u>	<u>1959</u>	<u>1960</u>
1. NET SALES FOR:			
a. Human Pharmaceuticals	80.5% (99.2)	73.8% (98.8)	84.2% (98.7)
b. Veterinary			
Pharmaceuticals	1.4%	1.6%	1.6%
c. Proprietary Medicines	1.0%	2.9%	0.7%
d. Chemicals	3.8%	7.6%	5.7%
e. Other Products	12.2%	12.9%	6.4%
f. Other Income	1.1% (0.8)	1.2% (1.2)	1.4% (1.3)
TOTAL	100.0%	100.0%	100.0%
2. WAGES AND SALARIES	23.7% (22.0)	22.8% (21.9)	24.3% (21.5)
3. EMPLOYEE BENEFITS	1.8% (1.6)	1.7% (1.7)	1.9% (1.7)
4. MATERIALS	32.7% (46.5)	32.3% (46.2)	28.7% (44.5)
5. EXCISE AND SALES TAXES	5.1% (3.5)	6.0% (3.0)	6.2% (4.7)
6. OTHER EXPENSES	23.2% (14.2)	23.4% (13.4)	26.2% (15.2)
7. DEPRECIATION	1.5% (4.0)	1.6% (3.6)	1.7% (4.1)
8. TAXES ON INCOME	5.5% (3.6)	6.0% (4.2)	5.5% (3.9)
9. PROFIT	6.5% (4.6)	6.2% (5.1)	5.5% (4.4)
TOTAL	100.0%	100.0%	100.0%



BB/MR/hm

1 MR. WHITELEY: I am afraid I still cannot
2 follow that point.

3 MR. HUME: Supposing Mr. Whiteley you have
4 a company with one million dollars sales with a thousand
5 dollars invested capital in Canada. Now if you take the
6 one million dollars sales in relation to the warehouse which
7 he bought for \$1,000.00, this looks like a very profitable
8 company.

9 Supposing it cost that company \$999,999,000 to
10 buy the product which they are importing and on which you
11 made one dollar in the year, it is not then a very
12 profitable company.

13 THE CHAIRMAN: That wouldn't be much of a
14 percentage.

15 MR. HUME: That is right. I used an extreme
16 example. I can take a figure, a hypothetical figure that
17 would, in my submission, would make it in line, but I merely
18 pointed out that mere investment capital if you have got to
19 pay more for your goods, is not necessarily as good a criterion
20 as the one which I submit we did not develop, but the
21 Canadian manufacturers have developed.

22 MR. WHITELEY: Let's follow that point.
23 Let's say they made only a quarter of one per cent on sales
24 but on terms of its capital in Canada it made a thousand
25 per cent return, wouldn't the parent company find it
26 worthwhile to put that amount of capital into Canada for
27 that return?

28 MR. HUME: I think that might be true, they
29 might. I am not suggesting it is not a good return. I am
30 only pointing out that if you relate sales to invested



1 capital you do not necessarily get as good a picture as
2 you do as a return on the sales dollar.

3 MR. WHITELEY: The question was the net
4 profit on the investment.

5 MR. HUME: Oh well, sure, if you related it
6 to that you are quite right. I am not suggesting that
7 having a good profit on an investment is not as good a
8 criterion as the Canadian Manufacturers have taken; taking
9 the net profit on sales dollar for the reasons which I have
10 outlined. I suppose it is a matter of opinion.

11 MR. WHITELEY: But the reasons you have
12 outlined do not appear to me to be logical.

13 THE CHAIRMAN: I was suggesting that if I were
14 investing in a company, buying some shares, and the return
15 on the invested capital showed 50% on the share capital,
16 I would think that is a nice company to have my money in
17 even though the per cent of net profit on sales might be
18 five or six per cent because the volume of sales might be
19 such that the profit on the invested capital would be
20 quite large.

21 MR. HUME: I concede that. I am not
22 suggesting that the other approach is not all right. Mr.
23 Conder has -- this was taken in order to compare it with
24 the Canadian average. I may be perhaps incorrectly re-
25 producing what my understanding is that the reason that
26 the Canadian Manufacturers Association have adopted this
27 criterion is because this appears to be more representative.
28 Perhaps this is a matter of opinion. Dr. Dixon will have
29 something to say about that when I call on him tomorrow
30 morning. He is an expert.



1 MR. FRAWLEY: Mr. Chairman, may I make this
2 observation: In view of the fact that we are getting a
3 minimum -- I say "we" -- the public, not the Commission,
4 the Commission will get what it demands -- in view of the
5 fact that we are getting a minimum of information, that
6 nothing at all is being told about the picture as to
7 Schering in this kind of examination, or Parke Davis, or
8 Mead Johnson, or any of them, I would think that Mr.
9 Conder should do it both ways.

10 I would suppose that Clarkson-Gordon, if
11 they were so instructed, could do it both ways. Could do
12 it on an invested capital basis as well as on the dollar
13 basis.

14 MR. HUME: Well if Mr. Frawley will look
15 at page 18, the total net worth is shown as \$57,800,000.00
16 and Dr. Dixon points out to me that a simple mathematical
17 calculation indicates 12.3 per cent.

18 MR. FRAWLEY: Is that the complete answer
19 to this discussion that you have been having with the
20 Commission?

21 MR. HUME: Professor Dixon, or Dr. Dixon
22 is here and when he is presenting his evidence perhaps I
23 will remember to bring that out. He has given me the
24 figure which may well be the answer. The net return,
25 however, is shown.

26 THE CHAIRMAN: I was asking Mr. Conder,
27 because I think it would be of value to the Commission in
28 knowing what the profit picture is in relation to invested
29 capital. That is fairly important from an investor's
30 point of view.



1 MR. CONDER: Yes, it could be sir.

2 MR. WHITELEY: I understand the one purpose
3 of the brief is to throw further light on the green book,
4 or to bring out points which would have a bearing on
5 statements that were included in the green book. Chapter
6 14 of the green book deals with profits of drug firms in
7 Canada and there are listed 28 firms. Are all those 28
8 firms included in this 40?

9 MR. CONDER: No sir. There are several of
10 those 28 firms which are not members of our Association.
11 Aside from that I think that you will note the others will
12 all be in here. All member companies will be included from
13 that 28 in our 40.

14 MR. WHITELEY: I am not sure -- I have not
15 checked through your entire brief -- is there a list of
16 the 40 companies given?

17 MR. CONDER: No sir, there isn't.

18 MR. WHITELEY: I wonder if we could have that
19 list?

20 MR. CONDER: You may sir.

21 MR. WHITELEY: The other point is that the
22 statement as to profits given in Chapter 14, statement that
23 profits before taxes and the statement appears on page 17
24 the following are statements of profits after taxes. I
25 believe the amount of taxes is shown on page 18. The
26 taxes are 5.5 per cent. And profits, assuming after taxes,
27 are also 5.5. Is it correct to add those two together in
28 order to get the profits before taxes?

29 MR. CONDER: That is correct.

30 MR. HUME: 11%, yes.



1 MR. WHITELEY: Whereas the figure given in
2 Chapter 14 I think is 17.08% Page 147. ---

3 MR. HUME: I might point out this is for
4 the year 1960 and the Green Book I think covers 1958.

5 MR. WHITELEY: This is on page 19. You
6 have the earlier year.

7 MR. HUME: What we have tried to do with
8 this figure -- you were drawing attention to page 18 --
9 what we have tried to do is bring the figure as up to date
10 as possible. We have attempted to show the comparison
11 from the previous surveys and to that extent if you take
12 1958 it would be 12%.

13 MR. WHITELEY: As against this figure of
14 17?

15 MR. HUME: Yes.

16 MR. FRAWLEY: Is Mr. Conder going to comment
17 on what is said in paragraph 231 of the Green Book?

18 MR. CONDER: I would comment this way sir
19 that this survey is based on 28 firms. Our study here is
20 based on 40 companies and the survey, I can assure you,
21 was an independent survey undertaken by Clarkson-Gordon
22 & Company, Toronto.

23 The only answer we would have for the variance
24 between the two figures is that the larger number of
25 companies has undoubtedly brought this down.

26 MR. WHITELEY: I was coming to the table
27 down in the middle of page 147 which gives a distribution
28 of companies by profit rate. I was wondering from your
29 surveys if you could provide the Commission with a similar
30 break-down?



1 MR. CONDER: I don't know whether Clarkson-
2 Gordon have retained these figures but I can check with
3 them and let you know sir.

4 MR. WHITELEY: Thank you.

5 MR. CONDER: On page 19 is the Analysis
6 of the sales dollar in percentages for 1958, 1959 and 1960.
7 On the top of the page here there is the year of the survey,
8 the number of firms replying to each survey and the company
9 which handled or correlated the returns from the survey
10 companies. These are put into percentages for each year
11 and the figure in brackets following the percentages are
12 the comparable figures for the Canadian Manufacturers
13 Association surveys for those years.

14 THE CHAIRMAN: What do these brackets 12 and
15 13 beside 1959 and 1960 refer to? Are they for notes?

16 MR. CONDER: The figures in brackets ---

17 THE CHAIRMAN: You have 12 ---

18 MR. CONDER: 12 and 13, those are the survey
19 numbers sir.

20 THE CHAIRMAN: Survey numbers?

21 MR. CONDER: For reference, as a cross
22 reference against the survey that we have here.

23 THE CHAIRMAN: How is it that in 1958 there
24 were 28 firms, the same number as the Director ---

25 MR. CONDER: We attempted in 1957 to implement
26 an annual statistical survey which was not too successful.
27 It was a pilot study in 1958. This was the first one that
28 got underway and frankly only 28 companies answered it.

29 Our companies had been loath for many
30 years to submit information to our Association or to other



1 groups based on what they considered confidential material
2 and information.

3 We are getting this up, and showing our
4 companies that information they provide to us is certainly
5 provided in the utmost confidence.

6 THE CHAIRMAN: I was wondering if the 28
7 in 1958 were similar to the 28 of the directors but some
8 of them are not members of your association?

9 MR. CONDER: No, these are all members of
10 our Association.

11 THE CHAIRMAN: Your 28 were. Some of these
12 were not?

13 MR. CONDER: No, that is true.

14 THE CHAIRMAN: Do you know how many of those
15 28 are not members of your Association, the 28 shown on
16 page 146 and 147?

17 MR. CONDER: At that particular time Robins
18 was not a member. It has since become a member. That is
19 frankly the only one at this stage.

20 The problem is this sir that the companies
21 listed on page 147, for example, may not all have con-
22 tributed to this particular survey so there would be a
23 considerable variance.

24 THE CHAIRMAN: I would like to know if you
25 can tell us whether these 28 are very nearly the same as
26 the ones that the Director referred to or whether there
27 is a very substantial difference.

28 MR. CONDER: I don't believe that I have
29 that in this information here. I have the names, as you
30 have requested, which I can present to your Commission



1 probably as a confidential exhibit if such a thing does
2 exist, the list of the surveys and the contributing
3 firms referred to and the reference attached to our
4 representations so we would have here, for example,
5 reference 12 we would look back into the reference 12 and
6 it would say see C.P.M.A. survey number 12 and then C.P.
7 M.A. would list all the firms here.

8 THE CHAIRMAN: If you give us this type
9 of information we will be able to make a fairly close
10 comparison with what the director has given to see whether
11 there is any in fact difference in the firms.

12 MR. HUME: The only pertinent year is 1958
13 and you do not have any reference number which indicates
14 that John S. Entwistle & Company, Toronto, do not have
15 those names. Is this so?

16 MR. CONDER: Yes, that is correct. We have
17 scrapped all that information.

18 MR. HUME: Then the subsequent years are
19 not in the green book. What you are going to hand the
20 Chairman -- you may hand it to him -- does not mean any-
21 thing. Your remarks Mr. Chairman are as to the 1958 survey?

22 THE CHAIRMAN: That is what I say. The
23 reason I asked about that, that is the number the Director
24 put in and they happened to have the same number of firms.

25 MR. HUME: Except for the one, so there
26 must have been one member ---

27 THE CHAIRMAN: At least one.

28 MR. HUME: ---reported here and one of the
29 28 on page 147. My point in rising ---

30 THE CHAIRMAN: There may be several others.



1 MR. HUME: I think the answer is Mr. Conder
2 that John S. Entwistle, a firm of chartered accountants in
3 Toronto apparently, as I understand it, they have destroyed
4 all the records. And what Mr. Conder is handing to you
5 is of no use to you, it covers 1959 and 1960. You may want
6 it.

7 THE CHAIRMAN: Not for comparative purposes.

8 MR. HUME: We will check with John. S.
9 Entwistle & Company.

10 THE CHAIRMAN: It may be of some interest
11 to us anyway.

12 MR. HUME: Well as explained in the green
13 book most of the figures are based on the year 1958. Now
14 we ran into the problem, which I suppose Mr. Conder did too,
15 or his surveyors that certain firms, their financial year
16 did not correspond with the calendar year so in each case
17 we got the latest figures available. These were collected
18 -- they were asked for the year 1959. In a few cases
19 the year might have ended in say June 1959 or something
20 likethat.

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1 MR. HUME: Chapter 140 is based on 1958 and
2 1959, I agree with that.

3 MR. MACLEOD: 1959.

4 MR. HUME: It was 28 as opposed to 43.

5 THE CHAIRMAN: I thought it was 1958. It
6 is 1959. I think we would like to have that information,
7 Mr. Conder, it might be of some interest to us for some
8 other purpose.

9 MR. CONDER: Yes sir. We don't release it.
10 This information is not made available to our individual
11 companies.

12 THE CHAIRMAN: This is a survey of contri-
13 buting firms referred to in, attached to the C.P.M.A.
14 representation. We will mark that as Exhibit T-6. The
15 envelope and its contents will be marked. It is for 1959
16 and 1960.

17 MR. CONDER: Yes, there are five different
18 surveys mentioned in our brief, and this is the breakdown
19 of the surveys.

20
21 --- EXHIBIT NO. T-6: Surveys attached to the C.P.M.A.
22 representation

23 THE CHAIRMAN: It covers these two and
24 three others, 1959 and 1960 surveys referred to on page
25 19 and three others as well?

26 MR. CONDER: Yes, that is right.

27 MR. WHITELEY: Perhaps for the record you
28 might distinguish - the Manufacturers' Association percen-
29 tage is given on page 19, you might indicate what the
30



1 first percentage is.

2 MR. CONDER: Do you mean 99.2?

3 MR. WHITELEY: Yes.

4 MR. CONDER: That will be for their net
5 sales for the year. The Canadian Manufacturers' Associa-
6 tion took their net sales which will be 99.2, for example
7 under the 1958 column and then they used what they call
8 other income and used the .8 in our particular industry
9 to give a greater clarification. We wanted to have
10 human pharmaceutical sales as opposed to sales of proprie-
11 tary medicine, chemicals and other products and other
12 income, so that we have the whole series which is more
13 convenient. A company in the machinery field, for example,
14 will not have any of these individual breakdowns.

15 MR. WHITELEY: I wanted to have that clear.
16 There is nothing to indicate what it is.

17 MR. CONDER: That is true.

18 MR. FRAWLEY: Is that a public document?

19 MR. CONDER: Yes, it is.

20 MR. FRAWLEY: Available from the Association?

21 MR. CONDER: It is published and I believe
22 it is distributed each year to companies which are members
23 of C.M.A. and also becomes a matter of public record
24 through release to the newspapers across Canada at that
25 time.

26 As we mentioned earlier, our Association
27 primarily represents companies which manufacture under
28 their own names in this country, but we also include in
29 our membership as Associate Members, non-manufacturing
30 subsidiaries of foreign manufacturers which maintain



1 adequate quality control facilities.

2 Most of our present Full Members which are
3 subsidiaries of foreign corporations, originally started
4 out on a small basis without Canadian production facili-
5 ties. In time, their volumes eventually reached the
6 point where it was economical to set up plants in this
7 country.

8 Based on our experience in this area, we
9 take issue with the statement on page 15 of the green book
10 which opines that "importations from the U.S. do not
11 assist in developing Canadian production facilities any
12 more than do importations from other countries". As a
13 flat statement, without qualification, this is incorrect.

14 It is an historical fact that U.S. importing
15 subsidiaries have eventually established more manufacturing
16 plants here than all other countries combined. In these
17 cases, importations from the U.S. have resulted in develo-
18 ping Canadian production facilities to a greater extent
19 than any other single source. Furthermore, the great
20 majority of these subsidiaries are headed up by Canadian-
21 born management who consider their operations wholly
22 Canadian. This is offered merely as a matter of fact,
23 for we hold no particular brief for U.S. subsidiaries
24 over those of other countries in our Association's day-to-
25 day operations.

26 The green book also states that "conditions
27 in the drug industry in Canada are influenced by conditions
28 in the U.S." Having studied other secondary industries,
29 the Commission realizes that this situation is not unique
30 to pharmaceutical manufacturing. Virtually every facet



1 of the Canadian economy is influenced by U.S. conditions,
2 including our labour unions. Whether we like it or not,
3 economic developments in Canada are strongly influenced
4 by corresponding movements in the United States, and
5 this is part of the price we must pay for our proximity
6 to a much larger and more highly industrialized nation.
7 The proximity, and resulting similarity between our two
8 peoples, has helped us to achieve one of the highest
9 standards of living in the world, and this standard is
10 even higher than many regions in the U.S.

11 Regardless of where the money came from,
12 Canada has now built for itself a strong and growing
13 domestic pharmaceutical manufacturing industry which is
14 largely self-sufficient at the secondary level. Even-
15 tually, even the primary raw materials will be made here,
16 and when that day arrives we will have a complete and
17 independent unit within the economy.

18 In the event of a major catastrophe, this
19 industry would be even more vitally important to Canada.
20 Should hostilities again break out, supplies would be
21 cut off and this industry would be required to fall back
22 on its domestic facilities to meet the needs of our nation.
23 Even now, our civil defence authorities at Ottawa are
24 examining the locations of our manufacturing plants to
25 determine which are in strategic areas. We certainly
26 hope that a world conflagration will not arise from the
27 present turmoil, but if it does then the nation will need
28 a home-based industry more than ever before in its history.

29 Price may be a short-term factor in importing
30 from abroad, but it is essential that we maintain our own



1 pharmaceutical manufacturing industry, for the service it
2 offers to the professions, for the employment it provides
3 our people, for the taxes it adds to the government's
4 coffers, for its general contribution to the economy in
5 peacetime, and for its value as a strategic industry
6 during hostilities.

7 PRICES

8 Much has been said about the so-called high
9 prices of drugs, and even the author of the green book
10 apparently takes it for granted that prices of drugs are
11 high. But "high" in what respect? The word price itself
12 is relevant. An automobile is high in price compared to
13 a loaf of bread. A pair of shoes costs more in Canada
14 than in Italy, but the Italian labourer must work more
15 hours than the Canadian to earn the money with which to
16 buy them.

17 Economists in retail pharmacy have shown
18 that in 1959, 46.3 per cent of the prescriptions dispensed
19 in Canada were priced at \$2.00 or less, while 58.8 per
20 cent were under \$3.00, and 88.6 per cent under \$5.00.
21 Only 1.1 per cent cost more than \$10.00. Granted, this
22 does not tell us whether drugs are reasonably priced.
23 But neither does it indicate that our companies are making
24 excessive profits.

25 THE CHAIRMAN: It doesn't indicate anything
26 about profits.

27 MR. CONDER: The only effective means that
28 we have of weighing this price factor is to apply it
29 against the usual economic indicators, the most common of
30 which is the Federal Government's Consumer Price Index.



From 1949 to 1960, the consumer price index for prescription drugs increased only 12.9 per cent and was, at the end of 1960, one of the lowest items in the overall consumer price index, as is shown by the following:

CONSUMER PRICE INDEXES - MAJOR GROUPS

<u>Classification</u>	<u>1949-60</u>
All Consumer Items	128.0
Food	122.2
Housing	132.7
Transportation	140.3
Recreation	141.6
Prescription Drugs	112.9

Obviously, the increase in the price of prescription drugs has not been as great as many items such as food and housing which are as vital to the health and well-being of Canadians as drugs. Furthermore, the following, according to DBS figures, shows that the price of drugs has not increased as much as health care costs in general.

THE CHAIRMAN: This probably isn't necessary but it doesn't seem to be in the study anywhere. You are saying 128, 122.2, 132.7 - I assume you mean '49 would be 100?

MR. CONDER: Yes sir, '49 is the base year listed at 100.

MR. WHITELEY: What is the composition of prescription drugs?

MR. CONDER: The composition of prescription drugs - it varies.

MR. WHITELEY: I mean in this index.



1 MR. CONDER: It varies according to a
2 variety of products which the Dominion Bureau of Statis-
3 tics takes and uses as the base. It doesn't cover all
4 the prescriptions. I believe they use a sampling of some
5 12, 15 basic products involved in this to reach their
6 conclusion.

7 MR. WHITELEY: The same list over the years?

8 MR. CONDER: I would hesitate to say defi-
9 nitely on that. I believe at some time they do modify
10 their indices and their basis on which they determine
11 their indices.

12 MR. FRAWLEY: Do you have that list, the
13 make-up of that list that is mentioned? Could you put it
14 on file?

15 MR. CONDER: The make-up?

16 MR. HUME: The D.B.S. publication.

17 MR. FRAWLEY: You don't know what steroids
18 and antibiotics and tranquilizers are included?

19 MR. CONDER: No, they don't break them down
20 separately.

21 MR. FRAWLEY: A person couldn't tell by
22 looking.

23 MR. CONDER: They were all prescription
24 drugs.

25 MR. FRAWLEY: You say you know it is a
26 selection?

27 MR. CONDER: That is correct.

28 MR. FRAWLEY: You know that from your conver-
29 sation with D.B.S., what they publish?

30 MR. CONDER: Yes.



1 MR. FRAWLEY: The nature of the selection
2 is not disclosed?

3 MR. CONDER: Not in here, no, not in the
4 monthly D.B.S. Report.

5 MR. FRAWLEY: So a person couldn't tell if
6 it included cortisone derivatives as an example in the
7 selection?

8 MR. CONDER: No, but I presume the Commis-
9 sion could if it asked the Dominion Bureau of Statistics
10 for it.

11 MR. HUME: They might tell Mr. Frawley if
12 he wrote them a letter.

13 MR. WHITELEY: Don't they publish letters
14 indicating the drugs in the indices?

15 MR. CONDER: Yes.

16 MR. WHITELEY: You don't have one concerning
17 this?

18 MR. CONDER: No, I am sorry I haven't, not
19 at this stage, but it is freely available. The next is
20 the consumer price indices, health care with the base of
21 1949 at 100 to 1960.

22 CONSUMER PRICE INDEXES - HEALTH CARE

23	<u>Classification</u>	<u>1949-60</u>
24	Health Care	158.7
25	Doctors' Fees	143.6
26	Dentists' Fees	154.8
27	Optical Care	131.6
28	Confinement	155.4
29	Prepaid Medical Care	172.6
30	Prescription Drugs	112.9



1 It is evident that during the 11 year period
2 ending 1960 drug prices in Canada showed a smaller increase
3 on the consumer price index than any other single element
4 of health care.

5 THE CHAIRMAN: We could get from D.B.S.
6 what the breakdown is. The "health care" is rather wide.

7 MR. CONDER: Health care?

8 THE CHAIRMAN: Health care might refer to
9 them all.

10 MR. CONDER: That is correct, it does.

11 MR. HUME: 158.7 is the overall average,
12 I understand. It is weighted.

13 MR. CONDER: It is the weighted average.
14 The other things all fall under the heading of health care.

15 THE CHAIRMAN: I doubt if it is an average
16 of 158.7. There is only one higher than that. It
17 would be a very high weighted value.

18 MR. CONDER: There are other items that are
19 included.

20 THE CHAIRMAN: All of the others are below
21 average. That is the only one above average. Prepaid
22 medical care shows 172.6 and all the others are less than
23 158.7 which would seem to indicate prepaid medical must
24 be a pretty important item in the list.

25 MR. CONDER: Yes.

26 THE CHAIRMAN: It is a weighted average.
27 It is perhaps the heaviest item, one of them anyway.

28 MR. CONDER: The next step is to determine
29 whether Canada's health care costs are in line with those
30 of other countries. The following chart compiled from a



1 study undertaken by the International Labour Organization
2 and covering the year 1955 shows at that time total
3 medical care costs, based on average income and purchasing
4 ability, were lower in Canada than in the United States,
5 United Kingdom, France, Norway, West Germany, Belgium and
6 Italy, as follows:

7 MEDICAL CARE COSTS BASED ON INCOME AND
8 PURCHASING ABILITY

9	<u>Country</u>	<u>Cost Factor</u>
10	West Germany	2.15%
11	France	1.98
12	Norway	1.91
13	United Kingdom	1.87
14	Denmark	1.82
15	United States	1.79
16	Belgium	1.70
17	Italy	1.66
18	CANADA	1.57
19	Netherlands	1.51

20 THE CHAIRMAN: Do you know how these figures
21 are derived, Mr. Conder?

22 MR. CONDER: I believe the International
23 Labour Organization in its study took the total medical
24 care costs of the country of origin and then they took
25 the average income of the individual and posed that against
26 the purchasing ability of the individual and then worked
27 that out on the basis of the medical care costs for a
28 comparison.

29 THE CHAIRMAN: Would they have gone by the
30 purchasing ability, what you could purchase for a given



1 income in Canada as compared to what you could purchase
2 for a corresponding income in another country?

3 MR. CONDER: This would be in the country of
4 origin, whichever country is mentioned.

5 MR. HUME: Is that a printed study that is
6 available, the International Labour study?

7 THE CHAIRMAN: It would be.

8 MR. HUME: You have seen it?

9 MR. CONDER: Yes.

10 MR. HUME: Does it describe in its glossary --
11 is it defined?

12 MR. CONDER: Yes, they describe in detail
13 how they go about it.

14 MR. HUME: Possibly, Mr. Chairman, it might
15 be easier if we got a copy and sent it to the Commission.
16 I am sure it is available to you. You possibly have it
17 in your library.

18 THE CHAIRMAN: Possibly we do. As it stands
19 here it raises some questions unless you know how it is
20 worked out.

21 MR. CONDER: Unfortunately, we were unable
22 to obtain more current figures. However, as consumer
23 price indices include health care, the following chart is
24 submitted to show that consumer prices of most of these
25 countries have increased more than that of Canada from
26 1953 to the third quarter of 1960.



1 MR. CONDER: Consumer Price Indexes by
2 Country.

3 THE CHAIRMAN: That is all consumer products,
4 is it?

5 MR. CONDER: Yes sir, that is right. This
6 is the consumer price index in each country.

7 CONSUMER PRICE INDEXES BY COUNTRY

8 <u>Country</u>	<u>Consumer Price Index</u>
9 France	134
10 Netherlands	122
11 United Kingdom	121
12 Norway	121
13 Denmark	120
14 Italy	116
15 Germany	114
16 United States	111
17 CANADA	111
18 Belgium	110

19 Consequently, in chronological order:

20 1. Consumer prices of most other countries
21 have increased more than those of Canada from 1953 to 1960.

22 2. In 1955, there was a lower proportion
23 of income spent on medical care in Canada, than in most
24 other countries.

25 3. Price of all other elements of health
26 care increased more than that for prescription drugs from
27 1949 to 1960.

28 4. During this same period, prescription
29 drugs have shown a smaller price increase than other
30 essential non-health items required to sustain life.



1 The price economics of any product depend
2 upon the conditions which, combined, make up the individual's
3 standard of living. And per capita income is the measure
4 of the individual's ability to afford the things which
5 make up his standard of living. Canadians have one of the
6 highest standards of living in the world, and there can
7 be no doubt that this is adding to our costs in all areas
8 of development.

9 As has been shown, the consumer price index
10 for drugs increased only 12.9 per cent from 1949 to 1960.
11 Yet it now costs our drug companies more to buy the
12 materials with which to manufacture these drugs. Pro-
13 duction and quality control equipment has increased in
14 price. And, more important, the thousands of employees
15 in our industry are making higher wages than ever before.

16 Average weekly wages in Canada in manu-
17 facturing increased some 78 per cent from 1949 to April
18 1961. This is far in excess of the comparable increase
19 for prescription drugs and leaves but one conclusion:
20 That the Canadian worker can better afford to buy drugs now
21 than he could in 1949.

22 THE CHAIRMAN: That is what you call
23 improving the standard of living?

24 MR. CONDER: Yes sir, it is.

25 We further submit that the prices of drugs
26 in Canada are actually low in relation to the comparable
27 purchasing ability of the average Canada. If a problem
28 does exist, then it is with a small percentage of the
29 population which, for reasons of substandard income or
30 chronic illness, finds it difficult to purchase all



1 commodities including drugs.

2 In addition, there are the relatively few
3 cases where a long-term user of drugs, even though he
4 is making an adequate wage, is faced with substantial
5 medical bills for doctors' fees and drugs. For instance,
6 the industry was incorrectly condemned in the House of
7 Commons for the cost of drugs required by the Dale children
8 of Ottawa who are afflicted with cystic fibrosis. Not only
9 were the costs submitted to the House incorrect, but
10 several of our companies were actually at that time
11 contributing free of cost to the Dale family the drugs
12 required in this case.

13 There is no doubt that the small number of
14 economic indigents in our population require serious
15 consideration, but this is no indication of a high price
16 of drugs any more than a family which cannot afford shoes
17 for its children is an indication of a high price of
18 footwear.

19 The average Canadian can well afford to
20 meet his drug bill, and the comparatively few exceptions
21 to this rule constitute a social problem to the nation
22 rather than one of industry economics.

23 COMPARISONS OF PRICES IN OTHER COUNTRIES

24 The green book states that prices in Canada
25 are "probably the highest in the world". This is
26 obviously based on the publicity statement issued by the
27 Kefauver Sub-Committee in the United States which
28 criticized Canada on the basis of the now renowned
29 chlorpromazine example. On product does not constitute
30 a drug industry, nor do antibiotics or ataractics typify



1 the economics of pharmaceutical manufacturing. In
2 themselves, they are important therapeutic substances,
3 but they represent only one facet of the industry's role
4 in medicine.

5 THE CHAIRMAN: Your contention would be
6 that these are not typical?

7 MR. CONDER: Not necessarily typical as
8 such.

9 THE CHAIRMAN: Do you say they are out of
10 line with what might be called "typical"? Are they very
11 different?

12 MR. CONDER: Based on this assumption, sir,
13 that approximately 84 % of the drugs dispensed in Canada
14 are not antibiotics or ataractics. The ataractics and
15 antibiotics might be termed the glamour boys of this
16 industry.

17 84% are not quite as glamorous in the
18 terms of the general public as are the antibiotics and
19 the ataractics, and yet these 84% are very, very important
20 therapeutic substances to the medical profession. I do
21 believe and I think it has been prevalent that much has
22 been based on antibiotics in particular over the years,
23 the past two years in particular, to the effect that the
24 antibiotics do represent this drug industry.

25 Many of the criticisms which have been laid
26 on our doorstep have been based on antibiotics and yet we
27 have many of these other products.

28 THE CHAIRMAN: What I am concerned about is
29 in what respect they may not be taken as typical. There
30 may be very good reasons for saying they are not typical,



1 but the Director in his studies seemed to think they were
2 fairly typical of the industry, and from the point of view
3 of the purposes he had in mind in the studies he was
4 making, if they are not typical, then the information which
5 he has obtained may not be as useful as he thinks it is.

6 We would like to know in what way, for what
7 reasons, you feel these facets of the industry, or the one
8 facet, as you call it here, of the industry, antibiotics
9 and ataractics, are not typical of the manner in which the
10 industry operates?

11 MR. CONDER: There may be various methods
12 in which the products are presented, in which the amount
13 of work put into discovering, of bringing about, and future
14 researching on these products -- which would be very
15 different from that of say the other 84% which do not fall
16 into this category.

17 THE CHAIRMAN: I can see you may have much
18 more research in this field than in many of the other
19 things where the drugs, perhaps, have become more standardized.

20 MR. CONDER: Yes. There is also this point,
21 that the antibiotics as such are not made by all companies.
22 It would be the same as saying an individual company, this
23 company makes an antibiotic product. This company may
24 also have 315 other products. It would not be economically
25 feasible to base this company on this one antibiotic
26 product because the factors involved in the antibiotic
27 production may be required to help support some of the
28 other low volume products which are part of the other 315
29 products.

30 We feel, ourselves, that no individual product



1 as such can determine the status or strength or economics
2 of an industry or of a company, that it must be taken into
3 consideration based on all the products which are manu-
4 factured by that company or industry and taken as averages.

5 Canadian drug prices are not necessarily
6 the highest in the world, although there can be no doubt
7 that Canada's standard of living is one of the highest in
8 the world. The purchasing ability of the individual is the
9 true indication of the reasonable price of any product,
10 and this indicator must be based on the number of hours
11 of work required to buy the product. Low consumer prices
12 invariably reflect low wages.

13 For example, the following table shows the
14 number of hours a bricklayer requires to earn a 1 kg. loaf
15 of bread in nine different countries.

16 It shows it ranging through here from
17 Japan at 47.8 minutes, Italy at 32.2 minutes, Germany at
18 25.1 minutes, Argentine at 20.2 minutes, Holland at 16.6
19 minutes, Belgium at 16.4 minutes, United Kingdom at 14.6
20 minutes, Canada at 7.3 minutes and United States at 6.6
21 minutes.

22 TIME REQUIRED TO EARN 1 KG. OF BREAD IN VARIOUS COUNTRIES
October, 1960

24 Japan, Tokyo	47.8 minutes
25 Italy, Rome	32.2 minutes
26 Germany, West Berlin	25.1 minutes
27 Argentine, Buenos Aires	20.2 minutes
28 Holland	16.6 minutes
29 Belgium, Brussels	16.4 minutes
30 United Kingdom	14.6 minutes



1 Canada, Toronto 7.3 minutes

2 U.S.A., New York 6.6 minutes

3 It has been further stated in the green
4 book that the price between Largactil in Canada and Thorazine
5 in the United States "reflects the usual relationship
6 between Canadian and U.S. prices" (i.e., \$6.25 to \$5.05)

7 THE CHAIRMAN: Which is said to be the
8 higher one?

9 MR. CONDER: It was \$6.25 in Canada to
10 \$5.05 in the United States. I believe, unless I am
11 mistaken, Mr. MacLeod, that the Kefauver one was in the
12 neighbourhood of \$7.00, and that you based \$6.25 on a
13 twenty unit price, calculating at $2\frac{1}{2}$ times that price to
14 get your \$6.25 which is certainly more prevalent.

15 THE CHAIRMAN: Perhaps you might get that
16 point cleared up now.

17 MR. MacLEOD: I think the main difference
18 was that the United States price -- the Canadian price as
19 reported to the United States Senate Committee appeared
20 to us to include a prescription fee, so we went to the
21 company's price list and took the prescription fee out.

22 MR. CONDER: Yes.

23 MR. MacLEOD: I think there is a 75¢
24 prescription fee taken off that.

25 MR. CONDER: I see.

26 MR. MacLEOD: The \$6.25 is I think taken
27 from Poulenc's published prices.

28 MR. CONDER: I think the differences might
29 also be based on something of this type: I unfortunately
30 do not have the exact page reference to this in here, but I



1 believe it was taken from a list. I believe that figure
2 was arrived at by taking a list. There is no list price
3 for 50 units. They have a list price for 20 and 100,
4 but none for 50.

5 It stated in the Green Book as I recall
6 in arriving at this \$6.25 figure, that this was based on
7 the 20 figure, and in order to get a figure of this type,
8 you must necessarily increase the 20 figure by $2\frac{1}{2}$ times.

9 It seemed to me personally at that time,
10 and it is purely a personal comment in this context, that
11 possibly a pharmacist might look at it from a different
12 viewpoint. He might take the 100 figure and say, "We will
13 take half of the 100 and come out with my figure," rather
14 than figuring out $2\frac{1}{2}$ times 20, which does make a considerable
15 difference.

16 THE CHAIRMAN: Or something in between?

17 MR. CONDER: Or something in between, but
18 it does make a difference. I checked with several pharma-
19 cists and with a couple of people at retail pharmacy
20 organizations. I phoned them up and I said, "What would
21 normally happen in this case?" They said invariably,
22 'we would definitely take half of 100, rather than $2\frac{1}{2}$
23 times 20.

24 MR. FRAWLEY: Have you got the dosage there
25 when you are speaking of the comparison of \$6.25 to \$5.05,
26 Mr. Conder? Is it 25 milligrams?

27 MR. CONDER: I don't know what page it is
28 on, Mr. Frawley, in the Green Book.

29 MR. MacLEOD: The page is number 204.

30 MR. FRAWLEY: And your page 26.



1 MR. CONDER: Yes, that is right. Yes,
2 that is 25 milligram tablets in 50's.

3 MR. FRAWLEY: In 50's?

4 MR. CONDER: Yes, this one we calculated
5 from the list price of \$2.50 for 20 tablets.

6 THE CHAIRMAN: Have we the price for 100
7 tablets?

8 MR. CONDER: The reason I got into it, sir,
9 is because someone told me quite some time ago when these
10 figures were being published that this figure was incorrect,
11 and when we eventually came into it, I checked up with
12 the company concerned and I said, "Why did you say at that
13 time that this figure was incorrect?"

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1 He said "Well, I will get the figures and
2 read them to you over the telephone", and the company did,
3 and there was a considerable difference on it. I forget
4 the exact figure now, but it was something in the five-
5 dollar range. I said "It seems unusual that this would
6 be the case, what is it for 100?", and he read the figures
7 out for me.

8 THE CHAIRMAN: You haven't the figure?

9 MR. CONDER: No.

10 THE CHAIRMAN: Very often there is a notice-
11 able difference by lots of 15 or 20 compared to lots of
12 100.

13 MR. CONDER: Yes, that is correct.

14 MR. FRAWLEY: In the report of the Kefauver
15 Committee on June 27, 1961, on page 37, they have a table
16 for Thorazine, and they show Canada, brand name Largactil,
17 company marketing, Rhone-Poulenc, price to the druggist,
18 \$3.75; in the United States, brand name Thorazine, company
19 marketing, Smith-Kline and French, price \$3.03.

20 MR. CONDER: Yes. \$3.75 is the same figure
21 that is contained in the Green Book, Mr. Frawley. It is
22 the same table. You take off our 10% for the elimination
23 of our sales tax there, and you come down to a figure of
24 \$3.37.

25 MR. HUME: I believe your comment is that
26 in the Green Book they have taken $2\frac{1}{2}$ times the price of
27 20 rather than half the price of 100, and you haven't got
28 the information as to what the price of 100 is?

29 MR. CONDER: No, not the exact figures, but
30 I would suggest, Mr. Hume, just for consideration, that



1 the people that I discussed this point with advised me
2 that the usual practice for a retailer would be to take
3 half the 100.

4 MR. HUME: Your comment is \$6.25 is still
5 too high?

6 MR. CONDER: Would be too high, if that
7 were the case.

8 MR. HUME: And you don't know what it should
9 be?

10 MR. CONDER: No, I didn't make a note of
11 the figure to bring along with me. I believe it could be
12 obtained from one of the price books which may be available,
13 but generally speaking there is a considerable variation
14 in the prices of drugs between the two countries, as is
15 shown by the table on the following page.

16 This table represents the products of 14
17 companies, which are sold in both the U.S. and Canada.
18 From an average of 86 products, 16 were higher in the
19 U.S. by 19 per cent, while 53 were higher in Canada by 13
20 per cent and this includes Canada's 11 per cent sales tax.

21 Comparisons of prices in Canada with those
22 of other countries should only be made less the 11 per cent
23 sales tax to obtain a proper differential when discussing
24 the manufacturers' or retailers' operations.

25 THE CHAIRMAN: Do you want to comment on
26 that?

27 MR. CONDER: Would you like to have the
28 table taken as read?

29 THE CHAIRMAN: I think it might be taken as
30 read. Is there any further comment to make?



1 MR. CONDER: None whatever.

2 MR. WHITELEY: These are suggested list
3 prices of manufacturers; is that it?

4 MR. CONDER: Yes, sir. This was the percen-
5 tage difference between list prices of Canadian and
6 United States companies based on products sold in both
7 countries. We did not work out the list prices ourselves.
8 We wrote to the companies and asked them to give us the
9 differences in each case, which they did, and these are
10 the only products which can be compared between Canada
11 and the United States.

12 THE CHAIRMAN: There are apparently quite a
13 number of products where the prices are higher in the
14 United States than Canada. Would those be products that
15 are imported in Canada from the United States?

16 MR. CONDER: I have no means of knowing
17 what products are involved in this.

18 THE CHAIRMAN: It would seem unusual if
19 they were ---

20 MR. CONDER: Some cases, depending on the
21 competitive nature of the market, as I understand.

22 THE CHAIRMAN: Very much difference if you
23 pay 11% sales tax and import duties and sell for less
24 than they sell for in the States.

25 MR. HUME: Is this table not adjusted to
26 eliminate the 11%?

27 MR. CONDER: The differences in prices do
28 include 11% sales tax.

29 MR. HUME: Oh, I see.

30 THE CHAIRMAN: Here is one here about half-



1 way down the page. In the first column, 176, that is the
2 total products compared by each company; 162 are higher
3 in Canada by about 11.7%.

4 MR. CONDER: Yes.

5 THE CHAIRMAN: And 14 are higher in the
6 United States by about 32.3%. That is a tremendous
7 difference in favour of Canada after you add 11% sales
8 tax.

9 MR. CONDER: Yes, that is true.

10 THE CHAIRMAN: And one at the bottom, 32.6%
11 difference there on 74 items.

12 MR. CONDER: Yes.

13 THE CHAIRMAN: Which is considerably more
14 than half the total.

15 MR. CONDER: Yes, that is right. I believe
16 you will find that much the same type of comparison can
17 be worked out from the figures in the Green Book which
18 we will be commenting on a little later.

19 THE CHAIRMAN: There is one here, 213
20 products, and apparently there are none higher in Canada,
21 and there is only one higher in the United States, and
22 the rest are all the same, and that one is 40% higher in
23 the United States?

24 MR. CONDER: Yes.

25 THE CHAIRMAN: I don't think there is any
26 obvious answer.

27 MR. HUME: Perhaps one obvious answer, Mr.
28 Chairman, might be that the Canadian importer under the
29 British Preferential Tariff is sometimes able to import
30 raw materials in Canada at a cheaper price than the



1 American manufacturer. I am not suggesting this is the
2 answer, but it is one answer I have read that indicates
3 that some things can be made cheaper here.

4 THE CHAIRMAN: The question in my mind is
5 whether a Canadian may not be importing from some other
6 place than the United States, but perhaps at a substan-
7 tially lower price of raw material, and the sale price
8 in Canada might be lowered --

9 MR. HUME: We haven't got that information.

10 MR. MACLEOD: Just for the record, the
11 price of Largactil tablets is set out on page 187 of the
12 Green Book, and the price for 100 is \$10.50.

13 THE CHAIRMAN: \$5.25 for 50?

14 MR. MACLEOD: If you cut it in half.

15

16 DIFFERENCES BETWEEN DRUG COSTS IN CANADA AND THE U.S.

17	Total				
18	Products				
19	Compared				
20	by each	No. higher		No. higher	
21	Company	in Canada	by %	in U.S.	by %
22	40	20	7%	8	10%
23	26	17	20%	5	10%
24	28	16	16.6%	12	4.4%
25	120	75	16.8%	42	18%
26	18	12	12%	3	11%
27	57	50	11.5%	7	15.2%
28	176	162	11.7%	14	32.3%
29	90	77	16.8%	13	21%
30	32	26	11%	6	(not incl.) "Varies" (not incl.)
	213	0	0	1	40%
	124	112	19%	10	17%



1	Total				
2	Products				
3	Compared				
4	by each	No. higher		No. higher	
5	Company	in Canada	by %	in U.S.	by %
6	26	19	16.5%	5	22.5%
7	145	109	11%	12	15%
8	<u>118</u>	<u>44</u>	<u>16.3%</u>	<u>74</u>	<u>32.6%</u>
9	86	53	13%	16	19% AVERAGES

10 Percentage differences between list prices of Canadian and
11 U.S. companies based on products sold in both countries.

12 MR. CONDER: And when we use a discount of
13 10 per cent to approximate the 11 per cent tax included in
14 the price of the product, we find some interesting facts.

15 For example, on page 203 of the green book
16 there is a comparison of prices to druggists of prednisone
17 for 10 countries. Using the footnote figure of \$19.87,
18 which is the more accurate of the two, and deducting sales
19 tax, we arrive at a price figure for Toronto of \$17.89.
20 As shown in the following table, this means that the price
21 of this product was lower in Canada than in the United
22 States, Italy, Panama, Australia and Japan.

23 You notice the prices to druggists of predni-
24 sone, we have no means of checking the figures to determine
25 whether they are correct, and we have merely taken them as
26 they stand from the Green Book, as I imagine Mr. MacLeod
27 was faced with taking them from the Kefauver table, but
28 if these figures are correct as stated, and by putting our
29 figure at Toronto at \$17.89, less sales tax, we can ana-
30 lyse the relationship.



PRICES TO DRUGGISTS OF PREDNISONE, 1959

<u>City and Country</u>	<u>Price to Druggist</u>
Tokyo, Japan	27.78
Sydney, Australia	24.00
Colon, Panama	22.99
Rome, Italy	22.16
United States	17.90
Toronto, Canada	17.89 (less sales tax)
Vienna, Austria	17.16
Amsterdam, Holland	16.05
Rio de Janeiro, Brazil	14.15
London, England	7.53

The average price for all 10 countries is \$18.76, which means that Canada's price is well below the average. And if we use the median as the basis for comparison, the price Canadians pay for this product is among the lower half of the 10 nations.

In another case, on page 206, we find a list showing the manufacturers' selling price to the druggist, of various brands of meprobamate. To avoid price differences among competing products, we will use Equanil for comparison which, less sales tax, would be sold to the pharmacist for \$3.24, indicating the following comparison:

PRICES TO DRUGGISTS OF EQUANIL, 1959

<u>Country</u>	<u>Price to Druggist</u>
Venezuela	5.44
India	4.25
Iran	3.55
Australia	3.47
United States	3.25



1	<u>Country</u>	<u>Price to Druggist</u>
2	Canada	3.24 (less sales tax)
3	France	2.65
4	Japan	2.56
5	Brazil	2.20
6	Mexico	1.80

7 Here we find that the average of the total
8 for these 10 countries is \$3.24, exactly the selling price
9 to the druggist less sales tax, in Canada. Again the
10 median indicates clearly that the Canadian price is among
11 the lower half of these countries.

12 These two cases cover an antibiotic and
13 ataractic, and are offered as evidence that manufacturers'
14 prices of pharmaceuticals in Canada are not among the
15 highest in the world. In fact, they compare most favourably
16 with world prices.

17 THE CHAIRMAN: Weren't Canadian prices that
18 were quoted or stated to be the highest in the world inclu-
19 sive of the sales tax?

20 MR. CONDER: Yes, sir. Our whole philosophy
21 behind this particular argument is that in comparing
22 prices between different countries then we should auto-
23 matically consider the Canadian 11% sales tax, and delete
24 that to show a comparative ratio among countries.

25 THE CHAIRMAN: Do you know about the taxes
26 in the other countries?

27 MR. CONDER: To the best of our knowledge
28 there is no federal sales tax applied against drugs in
29 any of these nations.

30 THE CHAIRMAN: Do you know if there are any



1 other taxes applied?

2 MR. CONDER: In other words, you would
3 suggest state taxes for example, or provincial taxes?

4 THE CHAIRMAN: I don't know what there
5 would be. These countries have all sorts of taxes.

6 MR. CONDER: Yes, that is true. This was
7 taken on the basis of federal.

8 THE CHAIRMAN: Yes, and they have sales tax
9 in the United States on most of the drugs, and comparing
2 10 the two, there may be some justification in taking it off
11 the Canadian price, but it doesn't pay for it. It
12 includes the tax?

13 MR. CONDER: Yes, that is true.

14 THE CHAIRMAN: You can't blame the drug
15 companies for that, but whoever is paying has to pay it.

16 MR. CONDER: Yes.

17 THE CHAIRMAN: Whoever is responsible.

18 MR. HUME: The point is, Mr. Chairman,
19 everyone does blame the drug companies.

20 THE CHAIRMAN: They are not responsible
21 for this, but if you pay \$10 for a drug, it is still \$10
22 whether \$1 is tax or whether there isn't any tax?

23 MR. FRAWLEY: Do you happen to know the
24 dosage of that Equanil you are talking about there on
25 page 29?

26 MR. CONDER: I think it will be contained
27 on page 206, as we mentioned, in the Green Book, Mr.
28 Frawley.

29 MR. FRAWLEY: Yes.

30 MR. CONDER: 4-milligram tablet in 50's.



1 However, as was pointed out earlier, two
2 products do not make an industry. Pages 210-213 of the
3 green book contain a list of 69 items showing a direct
4 relationship between prices in Canada and those in the
5 U.S. For this reference, we have used the revised figures
6 for one of the products, perphenazine, subsequently
7 submitted during the hearings by Mr. MacLeod.

8 Removing the 11 per cent sales tax from the
9 Canadian products, as this tax does not apply in the U.S.,
10 we find that of these 69 items:

11 The prices of 11 are even or within 3¢
12 of each other;

13 The prices of 30 are lower in Canada
14 than in the United States;

15 The prices of 28 are lower in the United
16 States than in Canada.

17 If hospital purchasing agents in the two
18 countries bought all of these drugs for their respective
19 hospitals at these prices, less sales tax, the total costs
20 would be as follows:

21 United States - \$1,589,97

22	Canada	-	1,641.35
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23 The actual difference is only \$51.38 or
24 about 3 per cent higher in Canada, and this can be accounted
25 for by differences between some 3 or 4 dosage forms repre-
26 senting a couple of products out of the 69. In view of
27 the fact that it costs considerably more to do business in
28 Canada than in the United States, it is surprising that
29 this differential is not greater.

30 THE CHAIRMAN: I am wondering if you have



1 the data from which that statement is made? With regard
2 to some items I think that would be true, and with regard
3 to some others it may not be true. I think, for example,
4 generally speaking wages and salaries are lower in Canada
5 than in the United States, while your cost of transporta-
6 tion and relative cost of detail work in that country may
7 be higher?

8 MR. CONDER: Yes.

9 THE CHAIRMAN: Where does the balance come
10 between those two? Some elements of cost are lower in
11 Canada and some are higher.

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FF/MR/hm

1 MR. HUME: Mr. Chairman, I think generally
2 speaking this is based upon the well repeated and oft
3 advanced cry that Canadian manufacturers require tariff
4 protection in order to compete with other countries because
5 it costs more to do business in Canada and we have tariff
6 protection in a great many fields. I think that if it
7 did not cost more to do business in Canada, Canadian
8 manufacturer of an automobile could compete quite success-
9 fully but there is a tariff on the Lincoln Convertible
10 because he cannot and the same with refrigerators and
11 electric motors and a great many items and it is based,
12 as I understand the whole tariff programme that it costs
13 more to do business in Canada. That is a general statement
14 and all general statements are very dangerous. This is
15 the basis upon which this is submitted.

16 MR. FRAWLEY: Tariff revenue.

17 MR. HANSARD: There is also the question
18 of the very great variation in the market volume. Fantastic
19 difference there.

20 THE CHAIRMAN: That is one of the elements.
21 What I am saying is when you have a variety of figures
22 entering into cost you cannot make one general comment that
23 it costs more to produce in Canada than the United States
24 with any assumption it is right without breaking that
25 down.

26 MR. CONDER: We attempt to do that following.

27 THE CHAIRMAN: You do that?

28 MR. CONDER: Yes. If anything, the prices
29 of pharmaceuticals in Canada should be higher than in the
30 U.S., regardless of our sales tax, for the following reasons:



1 The first point comes down into actually
2 four points.

3 1. Most raw materials must be imported
4 from the U.S. and other nations, at a cost of anywhere
5 from 15 to 20 per cent more than that paid by the U.S.

6 THE CHAIRMAN: This is for transportation
7 or is that sales tax?

8 MR. CONDER: That could be a variety of
9 things depending on the product involved, or the equipment,
10 the tariff rate on the import duty.

11 MR. WHITELEY: You get the first item, raw
12 materials imported from the United States and other nations.
13 It is dutiable if imported from the United States? It
14 is subject to duty?

15 MR. CONDER: Yes.

16 MR. WHITELEY: It would depend on the
17 relative tariff level that the United States has against
18 Canada?

19 MR. CONDER: That is true.

20 MR. WHITELEY: What is that relative level?

21 MR. CONDER: I am afraid I cannot say.

22 MR. WHITELEY: That first statement would
23 have to be qualified.

24 MR. HUME: As I understand the tariff, and
25 perhaps I can assist by indicating the tariff is a Statute
26 of Canada. There are three items in the tariff. It
27 doesn't matter where it comes from. Doesn't matter whether
28 it is the United States ---

29 MR. WHITELEY: You are not getting my
30 point. The question is there are importations from the



1 United States and importation from other nations.

2 MR. HUME: Yes.

3 MR. WHITELEY: Now the statement is then
4 made it costs anywhere from 15 to 20 per cent more in
5 Canada than the United States. Now it may be that some
6 of the American manufacturers are doing the same as the
7 Canadian manufacturers: They are importing from other
8 nations. Their cost would depend on the relative tariff
9 level of the United States as against other nations.

10 MR. HUME: You are quite right. The figure
11 that was quoted here was on the basis that on the overall
12 picture the Canadian manufacturer pays out between 15 and
13 20 per cent more than the American manufacturer. This is
14 I suppose because of the great volume that comes in from
15 the United States as opposed to other countries.

16 MR. WHITELEY: That could be a factor.

17 MR. CONDER:

18 2. The Canadian market is less than 10
19 per cent the size of the U.S. market, and therefore not
20 conducive to comparable mass production techniques.

21 3. About 17 per cent of all pharmaceutical
22 and medicinal products sold in Canada are imported, thereby
23 cutting down still further on the size of the domestic
24 market for Canadian manufacturers.

25 4. Because of the widely dispersed Canadian
26 market, the Canadian manufacturer must pay more in trans-
27 portation and distribution costs than his U.S. counterpart.

28 For these reasons, per unit costs are higher
29 in Canada than in the United States. We will not enlarge
30 on these four points, for they are well recognized in this



1 country. Further details may be found in Appendix C of
2 our representation to the Ontario Government's Select
3 Committee on Drugs, a copy of which is attached.

4 THE CHAIRMAN: I am wondering did that
5 contain any of the other side of the picture, the Canadian
6 cost? It may be lower than ---

7 MR. CONDER: No, it doesn't sir.

8 THE CHAIRMAN: We will take a short recess.

9

10 ---Short recess.

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GG/PB/hm 1 PROFITS

2 It is accepted that in the free enterprise
3 system which operates in Canada, the profit motive plays
4 an important part. Profit is the reward for the use of
5 capital and for the taking of risks. We assume that no
6 one questions the right of the pharmaceutical manufacturers
7 to earn a reasonable margin of profit in their business.

8 In the field of pharmaceutical manufacturing,
9 profits have been the spur to research and development
10 which has produced more new drugs in the past decade than
11 in the preceding twenty centuries. These same profits have
12 also enabled subsidiaries of foreign corporations to
13 establish manufacturing plants in this country, thereby
14 adding measurably to employment and the economic health
15 of Canada.

16 The rate of profit considered reasonable
17 for any particular industry will vary, depending upon the
18 type and nature of that industry and its products. A
19 company which has a stable product, with little competition
20 and fairly constant volume of sales from year to year,
21 can attract capital with a fairly low margin of profit. On
22 the other hand, an industry which is new, or which is
23 constantly changing, or which has products subject to style
24 changes or rapid obsolescence for one reason or another, will
25 require a higher margin of profit in order to attract
26 capital.

27 We submit that in this industry there is a
28 high degree of financial risk, in that a product may
29 become obsolete overnight with the introduction by a
30 competitor of a more effective therapeutic substance. The



1 life span of a drug may be comparatively short and the
2 company must necessarily take this into account. As
3 competitive products appear, sales of the corresponding
4 product by the company will gradually account for a smaller
5 percentage of the market. It must then switch its em-
6 phasis to other products, or find a new product to replace
7 the one which has become obsolete. In addition to taking
8 into account this risk factor, a company must assume that
9 its high volume products will support its low volume
10 products.

11 The fact that there is a high degree of risk
12 in the pharmaceutical business is borne out by the per-
13 centage of loss companies in this industry which, over the
14 six year period ending 1958, was higher than that for the
15 average of all manufacturing industries. In a sampling
16 of ten selected industries during the same period
17 pharmaceutical manufacturing, in number of losses sustained,
18 was second only to that of machinery manufacturing. We
19 suspect that much of the misunderstanding concerning
20 pharmaceutical manufacturers' profits has resulted in
21 publicity emanating from the United States regarding mark-
22 ups on drug products reputed to be in thousands of per cent.
23 This has perhaps created the illusion that the spread
24 between raw material costs and suggested list prices is
25 pure profit to the manufacturer. This is completely unrealis-
26 tic and unsound and ignores all the costs of manufacturing
27 and selling the product, quite apart from the development
28 and research costs that may be involved and the tax that may
29 be levied against the company. It is our submission that
30 the profits generated by the pharmaceutical manufacturers



1 in Canada are in fact fair and reasonable.

2 In the reference to profits in the green
3 book, rates of return are shown on pages 147 and 151 in
4 the form of profits before taxes as an indication of the
5 "profit on sales". We think it more realistic to look
6 to the real earnings of the company as the profits after
7 income taxes have been paid. In the table submitted
8 earlier in this brief it was shown that for 1960, 40
9 pharmaceutical manufacturers taking part in our survey
10 had combined profits after taxes of 5.5 per cent of sales.
11 Similar figures for 1958, 1959 and 1960 compared with
12 averages for all manufacturing industries published by
13 the Canadian Manufacturers Association are as follows:

14	<u>YEAR</u>	<u>CPMA</u>	<u>CMA</u>
15	1960	5.5%	4.4%
16	1959	6.2%	5.1%
17	1958	6.5%	4.6%

18 While the C.P.M.A. figures were compiled
19 from annual surveys of our member companies, they neverthe-
20 less are indicative of the industry average. The Department
21 of National Revenue in its publication of manufacturing
22 statistics shows that the pharmaceutical industry in Canada
23 made a profit after tax of 6.5 per cent for the year 1958,
24 which corresponds with the result obtained in our survey.
25 It is submitted that to anyone who has knowledge of profit
26 margins, the average profit of the pharmaceutical manu-
27 facturing industry is not unreasonable and, in fact, for
28 1960 is only very slightly higher than that obtained for
29 all manufacturing industries in Canada.



1 RESEARCH AND DEVELOPMENT

2 Since the dawn of time, man has sought to
3 find a miracle substance which would cure disease and
4 alleviate illness. Next to the alchemist's formula for
5 synthetic gold, this was the greatest single aim of pre-
6 dawn science and the men who practised this art were looked
7 upon with a mixture of awe and fear.

8 By the mid-centuries, this fear of the un-
9 known had transcended reason to the point where our early
10 researchers were accused of black magic and condemned by
11 the laity.

12 It was not until the end of the 18th
13 century that medical research won a modicum of recognition,
14 and even then it was looked upon with suspicion. As
15 recently as 100 years ago, the acceptance of medical
16 research had not regained the complete freedom and respect
17 it had won some 2,000 years earlier.

18 Then, with the turning of the 20th century,
19 came the complete enlightenment essential to the furtherance
20 of science. And scientific medicine eventually broke the
21 barrier nature had erected around the molecular structure.
22 Within the life span of everyone in this room, medical
23 research has produced the greatest period of discovery
24 in the history of man.

25 The term "wonder drug" was not an innovation
26 of the pharmaceutical manufacturing industry. It was a
27 coined invention of the press during the early days of
28 the antibiotics, as a means of referring to the startling
29 transition in medicine wrought by the steady stream of new
30 therapeutic substances.



1 But memories are short-lived. We are prone
2 to forget the limited medical armamentarium of 25 years
3 ago. The spiralling standard of living has brought with
4 it the fear of exorbitant price. And price is now being
5 considered an alternative to future discovery. The
6 world's pharmaceutical manufacturers which have produced
7 the majority of our so-called wonder drugs, admittedly
8 for the motive of profit as with most other activities
9 in our market economy, are being condemned for extravagance
10 and their motives subject to trial by headline. In fact,
11 the very substantial discoveries of the industry have
12 been belittled in the United States, and even in our own
13 House of Commons.

14 As the industry stands at the dock of
15 public opinion, we might well ask ourselves whether lack
16 of knowledge and misunderstanding will again result in a
17 roadblock to future discovery; whether research will again
18 recede into the fear of the unknown. Dramatic though this
19 may appear on the surface, movements are under way which
20 would seriously undermine research by private enterprise.
21 Regardless of the work of government, the curtailment of
22 free enterprise laboratories will hamper the pace of
23 research and discovery.

24 Will will not reiterate in this submission
25 the pharmaceutical manufacturing industry's contributions
26 to medicine, for these are explained in the attached copy
27 of the representation which we made before the Ontario
28 Government's Select Committee on Drugs, under Appendix D.
29 But at the present time there is no missile gap in pharma-
30 ceutical research, and there can be no doubt that thousands



1 of Canadians living today owe their lives to new thera-
2 peutic substances discovered or developed by scientists
3 working in the laboratories of pharmaceutical firms.

4 Granted, compared to a nation the size of
5 the United States, Canada's role in the field of pharma-
6 ceutical research is comparatively small. But we are
7 presently a small nation, even though we do have a
8 tremendous potential. As our population grows, and our
9 domestic markets increase, our industry will eventually
10 gain its rightful place in the scheme of international
11 research.

12 Concrete signs of this future development
13 are now on the horizon. Some of our companies already
14 have extensive research laboratories in this country, and
15 this has given Canada a good foothold in pure and applied
16 research. And at least one of these commercial laboratories
17 is among the largest research establishments in Canada and
18 is devoted solely to the field of pharmaceuticals.

19 Other pharmaceutical companies, particularly
20 subsidiaries of foreign research houses, are commencing
21 to build up pharmaceutical research laboratories in their
22 Canadian operations. Still others are contributing
23 experience and finances to our independent researchers and
24 universities.

25 As evidence of the significance of this
26 assistance, we are attaching to this submission under
27 Appendix E, a list of 158 research studies and fellowships
28 published in the Canadian Medical Association Journal
29 between January 1958 and June 1961, which were supported
30 by pharmaceutical manufacturing during that period. At



1 best it is merely a partial list appearing in one journal.

2 Clinical investigation in Canada has had a
3 significant growth over the past seven years, particularly
4 in respect to subsidiaries of foreign companies. As you
5 know, this is the final stage of a research project where
6 the new product is studied in humans under controlled
7 supervision after leaving the laboratory and before being
8 placed on the market. As recently as 1954, only a limited
9 amount of clinical research was being done in this country.
10 Since then the amount has mushroomed to the point where
11 today the clinical trials for a new product are usually
12 carried on in Canada simultaneously with the trials being
13 conducted in the country of origin. The contribution of
14 Canadian medicine in the clinical evaluation of drugs is
15 now widely recognized.

16 The clinical investigation state of
17 research and development usually comes under the aegis of
18 a company's medical director. The medical director, in
19 addition to his liaison with the medical profession, devotes
20 a large portion of his time to initiating and supervising
21 various clinical investigations to evaluate potential new
22 drugs. He is also required to check all medical literature
23 and other promotional material before release. His role
24 in the industry covers a wide area, and he must keep
25 himself constantly up-to-date on all new forms of treatment
26 and on the changes taking place in the practice of medicine.
27 They have their own section within C.P.M.A. which, in
28 turn, is affiliated with the Canadian Medical Association.

29 The following page contains the results of
30 two surveys of the research and development expenditures of



1 our member companies: One covers 22 companies for the
2 years 1958 and 1959 undertaken by C.P.M.A.; the other
3 covers 35 companies for the year 1960, undertaken by
4 Clarkson Gordon & Company of Toronto. For this survey,
5 we asked the companies to break down their research and
6 development expenditures incurred in Canada. In addition,
7 we asked for the share of research and development costs
8 charged to subsidiaries by parent corporations for research
9 undertaken in other countries, on the grounds that this
10 amount of money must be reflected in Canadian prices.

11 From the results of the Clarkson Gordon
12 survey, you will notice that these 35 firms accounted
13 directly or indirectly for total research expenditures
14 in 1960 of \$9,551,000. Of this amount, \$3,349,000 was
15 actually spent in Canada, while \$6,202,000 was incurred on
16 behalf of Canadian subsidiaries by foreign companies.
17 In addition, capital expenditures on research and develop-
18 ment laboratories and equipment in Canadian plants totalled
19 about \$3,000,000.

20 At this juncture, sir, you may wish to
21 refer to the tables.

22 THE CHAIRMAN: These are the tables of
23 totals of these 22 companies.

24 MR. CONDER: The top half is based on 22
25 companies for the years 1958 and 1959. The one at the
26 bottom is based on 35 companies for the year 1960 under-
27 taken by Clarkson, Gordon. The top half for the years
28 1958 and 1959 is based on our own surveys. The one on
29 the bottom is based on the Clarkson, Gordon survey. You
30 may notice the percentages given for 1958 to 1959 in the



1 upper table. It is, of course, not practical to attempt
2 to refer the bottom table to the upper two.

3 THE CHAIRMAN: There is a substantial
4 increase, but there is an increasing number of companies.

5 MR. CONDER: Yes sir, 13 more companies
6 here. -

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1 Then there would, of course, be a natural
2 increase from 1958 to 1959 for the companies which would
3 be covered in the previous survey.

4 THE CHAIRMAN: I see you show in 1958 and
5 1959 for those 22 companies the percentage of the total
6 cost of all research and development was 6.3%.

7 MR. CONDER: That is correct.

8 THE CHAIRMAN: And for the 35 companies in
9 1960 you have 8.3%. I think the Director's figures as I
10 recall them were somewhat less in total.

11 MR. CONDER: Yes I believe we comment on
12 that later in our submission, sir. The Director used a
13 figure based on the amount of research done, actually
14 done, in Canada by the companies involved, whereas these
15 figures, 6.3% and 8.3% also include the amount of research
16 which is chargeable against the Canadian operation by
17 parent companies.

18 THE CHAIRMAN: That is what I was going to
19 ask you a question about. At the bottom of page 36 you
20 say, "Of this amount, \$3,349,000 was actually spent in
21 Canada, while \$6,202,000 was incurred on behalf of Canadian
22 subsidiaries by foreign companies". Does that refer to
23 parent companies which engage in research and charge a
24 certain amount to Canada, or does it refer to requests by
25 a Canadian subsidiary for certain research to be done by
26 the parent company?

27 MR. CONDER: No, it would be the former.

28 THE CHAIRMAN: That is, the parent company
29 carries on its research and allocates a certain amount of
30 its research to Canada, and probably to other countries if



1 they have branches there.

2 MR. CONDER: That is correct.

3 THE CHAIRMAN: Could you give us any data
4 on this item, "Research projects underwritten abroad by
5 Canadian firms"?

6 MR. CONDER: Yes. In some cases Canadian
7 companies - and these will be primarily in this area
8 wholly-owned Canadian companies - will underwrite a speci-
9 fic research project in a research establishment in
10 another country which may be following a certain line of
11 discovery or which may have the facilities which are not
12 available in Canada for this work.

13 THE CHAIRMAN: Does that include the sort of
14 thing that Mr. Thompson was talking about in Switzerland?

15 MR. CONDER: It very well could, sir.

16 MR. HUME: I don't think Mr. Conder is
17 familiar with what Mr. Thompson said. Mr. Thompson indi-
18 cated the establishment in his company of a purely research
19 laboratory in Switzerland and indicated the Canadian
20 company might use these facilities. It paid to a certain
21 extent ---

22 THE CHAIRMAN: I think he said that his
23 company was contributing to them.

24 MR. HUME: Yes.

25 MR. CONDER: I was quite interested in this
26 point myself at that time, and those figures do not cover
27 that type of thing. It will be primarily the cost of a
28 wholly-owned company actually jobbing out a research pro-
29 ject or paying for specific research done in another
30 country.



1 THE CHAIRMAN: You may not be familiar with
2 the Nordic Chemicals. I think they have some relationship
3 which might come in that category with some Scandinavian
4 group. Are you familiar with their situation?

5 MR. CONDER: No, I am not. I do not know
6 too much about Nordic Biochemicals, but is Nordic Biochemi-
7 cals a wholly Canadian company, do you recall?

8 THE CHAIRMAN: It is an entirely Canadian
9 company, they told us.

10 MR. CONDER: Oh, I see. That would probably
11 apply in this particular area.

12 THE CHAIRMAN: They have some relationship,
13 some agency, some joint arrangement regarding research.

14 MR. CONDER: Yes, most companies today do
15 require that, most independent companies.

16 MR. FRAWLEY: Could you comment on the fact
17 in the item "Clinical Investigation", they received in
18 1959 \$362,889, and it jumped to \$1,022,000 in 1960. It is
19 the same item.

20 MR. CONDER: Yes, it is quite possible, Mr.
21 Frawley, that this differential - you will notice there
22 was a 20% increase in clinical investigation from 1958
23 to 1959. You will expect there will also be a significant
24 increase in clinical investigation from 1959 to 1960. On
25 top of this, the 1960 figures contain an additional 13
26 companies which were not in the other surveys.

27 MR. FRAWLEY: Don't misunderstand me. It is
28 quite commendable, but I could not understand how it only
29 rose 20% from 1958 to 1959.

30 MR. HUME: When Mr. Frawley is comparing



1 those figures, he forgets there are 20 companies in 1958
2 and 1959, and 35 companies in the 1960 figures and the
3 figure would naturally be less in 1958 and 1959. In 1960
4 there were 13 more companies.

5 MR. FRAWLEY: You must have got in some big
6 contributors.

7 THE CHAIRMAN: I think he is right to this
8 extent, that the increase in this particular item is much
9 greater than in the others.

10 MR. HUME: Yes.

11 MR. FRAWLEY: Is that the kind of work Dr.
12 Rodman was telling the Commission about in Edmonton?

13 MR. CONDER: I don't know Dr. Rodman, Mr.
14 Frawley.

15 MR. FRAWLEY: The clinical investigation in
16 the hospitals of a new drug, that is the kind of thing it
17 is, isn't it? Isn't it a new drug in the hospitals?

18 MR. CONDER: Yes it could be here, a hospital
19 or a private investigation.

20 THE CHAIRMAN: Does this survey indicate that
21 in 1960 the extension and use of Canadian facilities for
22 clinical research had a big step-up?

23 MR. CONDER: I believe it did have.

24 THE CHAIRMAN: In that particular year?

25 MR. CONDER: Yes.

26 THE CHAIRMAN: That was the sort of impres-
27 sion you would get from looking at these figures.

28 MR. CONDER: Yes.

29 THE CHAIRMAN: You refer to Canadian clinical
30 research being extended and Canadian facilities being used



1 to a much greater extent, and it would appear in 1960
2 there was a big jump forward in that respect.

3 MR. CONDER: Yes, there certainly was.

4 Could we have page 37 accepted as read?

5 THE CHAIRMAN: Yes. I was wondering if
6 everybody here has copies of the brief. When we take it
7 as read I hope nobody is in the dark if they want to ask
8 any questions.

10 RESEARCH AND DEVELOPMENT EXPENDITURES BY 22 COMPANIES

11 IN 1958 AND 1959

12		<u>1959</u>	<u>1958</u>	<u>% gain</u>
13	Total cost applicable to firms			
14	operating in Canada:	\$5,324,613	\$4,718,770	13%
15	Spent by foreign control on			
16	behalf of Canadian subsidia-			
17	ries:	2,614,900	2,288,757	14%
18	Actually spent in Canada:	2,500,165	2,238,185	12%
19	Research projects underwritten			
20	abroad by Canadian firms:	209,548	191,828	9%
21	Clinical investigation:	362,889	302,288	20%
22	Research gifts and grants:	327,784	298,358	13%
23	Capital expenditures on research			
24	and development laboratories and			
25	equipment in Canadian plants:	2,456,332	1,266,582	94%
26	Percentage of total cost of all			
27	research and development in rela-			
28	tion to Canadian net sales:			6.3%



RESEARCH AND DEVELOPMENT EXPENDITURES BY

35 COMPANIES IN 1960

Total cost applicable to firms operating
in Canada: \$9,551,000
Spent by foreign control on behalf of
Canadian subsidiaries: 6,202,000
Actually spent in Canada: 3,349,000
Clinical investigation: 1,022,000
Research gifts and grants: 414,000
Capital expenditures on research and develop-
ment laboratories and equipment in Canadian
plants: 2,968,000
Percentage of total cost of all research and
development in relation to Canadian net
sales: 8.3%

MR. CONDER: Referring to the survey covering
22 firms for the years 1958 and 1959, it is interesting to
note that these companies spent more on pharmaceutical
research in Canada in 1958-59 than that expended by either
the National Research Council or the Department of National
Health and Welfare for extramural medical research, as
reported in the green book. And the term medical research
in respect to these two government agencies is not limited
to pharmaceutical research. Furthermore, the voluntary
health agencies interested in specific diseases such as
arthritis, cancer and muscular dystrophy, cannot be consi-
dered an effective alternative to general pharmaceutical
research. A large portion of their funds must necessarily
be spent on education, and the expenditures on research
by these agencies go towards medical research in its broad



1 application.

2 It is for these reasons that we question
3 the comment in the green book that "research in Canada
4 appears to be regarded more and more as a responsibility
5 of government and of those private organizations interested
6 in particular diseases". In the field of drug research
7 Canada's pharmaceutical manufacturing industry is presently
8 doing its share of investigation.

9 If this research continues to grow at the
10 rate of 12-14 per cent per year, the annual expenditures
11 on research and development in Canada by these 35 firms
12 alone will have reached at least \$11,000,000 by 1970. Nor
13 does this take into account the anticipated growth of the
14 domestic market which will make it economically practical
15 for more and more companies to establish research facilities
16 in this country.

17 We must be realistic in viewing the future
18 of pharmaceutical research in Canada and the role of the
19 Federal Government in this respect. Had the U.S. Government
20 taken over all pharmaceutical research in that
21 country, and closed incentive to private enterprise, it
22 would now be faced with either adding another \$200,000,000
23 annually to its budget or curtailing that nation's current
24 research efforts. The coffers of government are not
25 bottomless.

26 It was coincidental that the 1959 research
27 surveys by our Association and the Combines Investigation
28 Branch each based its results on 22 companies, for our
29 survey was published before the Ontario Inquiry in
30 October, 1959, while the green book was not completed until



1 February 1960. Presumably the 22 firms reported by the
2 green book are included among the 27 firms listed on
3 pages 106-107. Our own survey resulted from returns of
4 28 firms, 22 of which replied to the research chapter of
5 the questionnaire.

6 Yet of these two lists, only 14 firms
7 appear on both. The green book contains the names of 13
8 firms which were not in our survey, while our survey
9 contains the names of 14 companies which were not included
10 in the green book survey.

11 Pro-rating the average of 2.12 per cent of
12 the total sales figure of \$94,600,000 mentioned in the
13 green book, produces a total expenditure on research in
14 Canada for these 22 firms of \$2,005,520. It will be
15 noticed above that our figure for the same period and for
16 the same number of companies was \$2,500,156. Both are
17 sufficiently close to bear favourable comparison.

18 However, there is one rather notable discre-
19 pancy. The 22 firms mentioned in the green book are
20 reported to account for total sales of \$94,600,000 whereas
21 our own annual statistical figure for the same period shows
22 43 firms with a total sales of human pharmaceuticals of
23 \$96,516,511. Even though some of the firms mentioned in
24 the green book were not covered in our survey, it is
25 doubtful that 22 companies would account for only about
26 \$2,000,000 sales.

27 As the author of the green book will no
28 doubt agree, statistical percentages can be confusing
29 unless the same terms of reference are used in comparisons.
30 For this reason, we venture that this \$94,600,000 figure



1 shown in the green book undoubtedly represents total sales
2 of all products manufactured by most of the companies in
3 question and not merely that of human pharmaceuticals.
4 For instance, our survey produced a total sales for 43
5 firms of \$130,755,546, whereas only \$96,576,511 of that
6 was in human pharmaceuticals. The balance, \$34,239,035,
7 comprised chemicals, proprietary medicines and other
8 products. If this is the case, then the percentage of
9 research expenditures to sales mentioned in the green book
10 is lower than it should be, on the premise that the ratio
11 on research for ethical pharmaceuticals should be limited
12 to sales of ethical pharmaceuticals.

13 Carrying this approach to its conclusion,
14 we suggest that the green book's percentage of research
15 should be closer to 3.1 per cent of sales rather than 2.1
16 per cent. This reasoning is based on the fact that our
17 own survey for the same year showed a percentage to sales
18 of 6.3 per cent, and this included research assessments
19 against Canadian subsidiaries by foreign parent companies.
20 As this assessment dollar-wise represented about half the
21 total research figures of 6.3 per cent, the balance would
22 work out to about 3.1 per cent for actual expenditures in
23 Canada. Again these figures are close enough to warrant
24 accounting comparison.

25 Comparisons with other industries have been
26 used in respect to profits, so it is natural that we
27 should use them here. The Dominion Bureau of Statistics'
28 publication entitled "Industrial Research-Development
29 Expenditures in Canada, 1959" shows the direct research-
30 development expenditures as percentage of sales for 15



1 major industries in Canada. All are well below pharmaceu-
2 tical manufacturing as is shown on the following page.

3 On page 42, Mr. Chairman, we give this lis-
2 4 ting with the footnote at the bottom, "'Industrial Research-
5 Development Expenditures in Canada, 1959' does not show
6 pharmaceutical manufacturing. The 6.3 per cent figure is
7 based on the C.P.M.A. survey".

8 MR. WHITELEY: Do you know how it deals with
9 this question of charges against subsidiaries?

10 MR. CONDER: Yes sir, we do come to that in
11 the text following. These figures give you charges from
12 parent companies to Canadian subsidiaries in these other
13 areas. I have a reference in here of the background.

14 THE CHAIRMAN: I suppose they may not all
15 have the same proportion of American parent companies?

16 MR. CONDER: In some cases, sir, I think you
17 will find it will be a large proportion of American parent
18 companies in some of these industries, but we are speaking
19 of percentages of the sales dollar, and not percentages of
20 actual expenditures as such in the chemical products,
21 which is the fourth one from the top, "Chemical products
22 (which include pharmaceutical manufacturing)". It is only
23 1.54%, but the fact remains that the pharmaceutical manu-
24 facturer's sales amount to such a small percentage of the
25 chemical industry that our relationship on the percentage
26 on research towards sales is much higher.

27 THE CHAIRMAN: It might very well be, of
28 course, because of the remarkable developments that have
29 taken place in the pharmaceutical field, that companies
30 are spending more relatively on research in that field



1 than they are in many others. I think that is true.

2 MR. CONDER: I believe that is an accepted
3 fact, sir. Could we have that table on page 42 taken as
4 read?

5 THE CHAIRMAN: Yes.

6
7 Direct Research-Development Expenditures as

8 Percentage of Sales, 1959

9 Direct research cost

10 as % of sales

11 Pharmaceutical manufacturing:	6.3%
12 Transportation Equipment:	1.90%
13 Electrical Apparatus and supplies:	1.81%
14 Chemical Products (which include pharma-	
15 ceutical manufacturing)	1.54%
16 Mining, Quarrying and Oil Wells	0.99%
17 Non-ferrous Metal Products	0.71%
18 Tobacco and tobacco products, leather	
19 products and miscellaneous manufacturing	
20 industries	0.65%
21 Textile Products	1.22%
22 Non-metallic Mineral Products	0.78%
23 Rubber Products	0.53%
24 Iron and Steel Products	0.40%
25 Paper Products	0.44%
26 Products of Petroleum and Coal	0.3%
27 Wood Products	0.23%
28 Transportation, storage, communication and	
29 public utility operations	0.14%
30 Food and Beverages	0.12%



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1 It will be noticed that our 6.3 per cent
2 figure has been used for pharmaceutical manufacturing,
3 as this includes research done outside Canada on behalf of
4 Canadian subsidiaries. The reason for this is that the
5 DBS survey was based on the same factor, and I might add
6 this was taken from the DBS publication, to "In order
7 to ascertain the total cost of research-development,
8 respondents were asked to report not only the cost of
9 their own activities in this field, but also payments made
10 to other companies or organizations both within Canada
11 and outside the country".

12 If the Dominion Bureau of Statistics uses
13 this as a proper basis for determining research expendi-
14 tures, then we should feel free to use the same basis,
15 showing the 6.3 per cent figure rather than merely the
16 amount actually expended in Canada. Either way, pharma-
17 ceutical manufacturing shows a higher ratio of research
18 to sales than all other major industrial classifications.

19 It is further significant that this same DBS
20 publication for the year 1957 (not shown in 1959 issue)
21 indicated the medical research portion of the chemical
22 industry, which would be primarily pharmaceutical manu-
23 facturing as having expended \$1,340,000 on research in
24 1957, as compared to other non-manufacturing (sic) which
25 primarily represents "hospitals maintaining research-
26 development establishments and medical foundations" at
27 \$1,108,000.

28 The Canadian pharmaceutical manufacturing
29 industry's research expenditures may be considerably less
30 than those of its U.S. counterpart, but there is no doubt



1 that in relation to other research in Canada, both medical
2 and general, our industry is one of the top contributors.

3 As our nation grows and the market for
4 pharmaceuticals in Canada expands, domestic pharmaceutical
5 manufacturers will be able to increase their research
6 facilities accordingly, and the nation will depend less
7 and less on other countries for the advancements essential
8 to the health of our people. This dependency will
9 gradually disappear, but only if this industry continues
10 to grow and prosper.

11 There is still another aspect of Canadian
12 research and that is the scientists who work in our
13 laboratories. The two surveys which we referred to earlier
14 showed the following breakdown of scientific personnel
15 employed by these companies. The next item, type of
16 research. This would be Ph.D., Doctor of Science or M.D.
17 The next is Master of Science or Equivalent; the next is
18 Bachelor of Science, Bachelor of Pharmacy or Equivalent,
19 and the Laboratory Technicians.

20 The next three columns are broken down
21 according to surveys. Our 1958-59 surveys were based on
22 22 firms, whereas our 1960 survey is based on 34 firms.
23 Taking the 1960 figures we have 102 Ph.D's and other
24 doctorates, 28 Masters, 90 Bachelor degrees and 142
25 laboratory technicians.

26 In 1959 it was 76, 18, 60 and 107 respec-
27 tively. In 1958, 74, 18, 54 and 100.

28 These 22 firms from 1958 to 1959, increased
29 their total scientific personnel from 246 to 261. You
30 cannot get the same co-relation of course with the 1960



1 figures because you have more companies in there, but
2 the 34 firms in 1960 employed 362 people who were employed
3 as scientific personnel in those companies engaged in
4 research and development work.

5 MR. WHITELEY: That wouldn't be exclusively?

6 MR. CONDER: Yes, sir. We said we want to
7 know the number of people employed in these companies in
8 research and development work who spend the largest part
9 of their time in this particular area. We don't want them
10 to include in there personnel which was working on purely
11 production or personnel which was working on purely quality
12 control in the quality control labs, and sometimes it is
13 a problem to divide personnel between quality control lab
14 and research lab. That was spelled out at that time.

15 THE CHAIRMAN: These people are primarily,
16 although not necessarily, all of them exclusively engaged
17 in research? You said the majority of their time?

18 MR. CONDER: I would say they were almost
19 exclusively engaged in it. There might be certain other
20 jobs on the side. Most of them are engaged primarily in
21 the field of research and development work.

22 THE CHAIRMAN: Mr. Whiteley has a question
23 where would you put the medical director? Would he be
24 included in the research?

25 MR. CONDER: That would depend a lot on the
26 company, the role and duty of the medical director of that
27 company. It does vary. In some companies, particularly
28 companies that have more than one medical director, they
29 will have one who I believe will specialize primarily in
30 the clinical investigation aspect.



1 THE CHAIRMAN: Clinical investigation?

2 MR. CONDER: Yes.

3 THE CHAIRMAN: He might or might not be
4 included depending on the particular set-up of the company?

5 MR. CONDER: That is correct.

6		34 firms	22 firms	
7				
8	<u>Type of Researcher</u>	<u>1960</u>	<u>1959</u>	<u>1958</u>
9	Ph.D., D.Sc., or M.D.	102	76	74
10	M.Sc. or Equivalent	28	18	18
11	B.Sc., Phm.B. or Equivalent	90	60	54
12	Laboratory Technicians, etc.	<u>142</u>	<u>107</u>	<u>100</u>
13	Total	362	261	246

14 These are scientific personnel employed
15 by some of the companies in our industry. As we stated
16 in our representation before the Ontario Government we
17 have in the past been losing many of our scientifically-
18 trained people to other nations, but the incentives at
19 home are commencing to improve. If we do not encourage
20 this conducive climate in relation to our growth, we will
21 discourage scientists, for scientists will not remain in
22 a country which does not offer opportunities for jobs and
23 advancement.

24 We represent a young industry which is
25 making a marked contribution to the health, economy and
26 scientific well-being of a growing nation. And we ask
27 not for political or economic favours, but merely for an
28 understanding of what our companies have and are accompli-
29 shing for the good of Canada.

30 PRODUCT NAMES

As the green book points out,



1 much confusion exists in the area of product names. Some
2 claim that by eliminating the trade name and using only
3 the generic name phenomenal savings can be realized in
4 price, completely ignoring the fact that economics of
5 business govern price and not merely the name assigned to
6 the product. Others claim that ethical pharmaceutical
7 companies sell under trade names are bitterly opposed to
8 generic names, again ignoring the fact that many of these
9 firms also sell under generic name.

10 Briefly, a trade mark or trade name identifies
11 both the product and the manufacturer of that product, while
12 a generic name merely identifies the ingredient.
13 Pharmaceutical manufacturers generally sell most of their
14 products under trade names and, as a result of their
15 advertising and performance, these products become known
16 and accepted by the medical profession.

17 THE CHAIRMAN: Trade names was the word
18 you used. It should be trade marks?

19 MR. CONDER: It should be trade names I
20 believe, yes.

21 Consequently, manufacturers or importers
22 dealing almost exclusively in generic names, invariably
23 sell their products as a direct result of the demand
24 created by and for the trade named products. For this
25 reason, it is usual practice for a company selling
26 primarily under generic name to pick up only those products
27 which have the greatest sales potential and for which a
28 market has already been created.

29 Competitively, the company selling under
30 generic name is not in as good a position as the company



1 which sells under its trade name, primarily because most
2 doctors will not readily prescribe products of unknown
3 manufacture. This, of course, could be overcome by using
4 the generic name along with the company name, but this
5 is the same principle as that of using a trade name.
6 Furthermore, to make its name known to the profession, the
7 company selling under generic name would have to advertise,
8 but by so doing it would add to its costs and so lose
9 its primary advantage of price. If all products could
10 be sold under generic name, this would tend to squeeze out
11 the smaller companies and thus curtail competition in the
12 industry.

13 The green book states, on page 25, that
14 "there appears to exist a concerted campaign to characterize
15 the products of certain firms which offer imported drugs
16 under their generic name as cheap imitations of inferior
17 quality." The word "concerted" means to arrange by mutual
18 agreement. If this statement is intended to apply
19 against the manufacturers we represent, then it is in-
20 correct.

21 Our Association has not arranged any such
22 campaign. Where statements concerning inferior quality
23 have been made, then we suggest that such statements are
24 founded on sufficient fact to warrant such claim.

25 The general tenor of our Association's
26 position in respect to generic names may best be summed
27 up in a statement made by Dr. Newell Stewart of the
28 National Pharmaceutical Council before one of our general
29 meetings: "While I know of no responsible person associated
30 with any pharmaceutical company who is critical of generic



1 names for drugs, there is great opposition to the idea of
2 equivalency of all drugs with the same generic name."

3 The term "generic name" which is a
4 substitute for the term "proper name" or for the term
5 "common name" has only been publicly used in its present
6 context in the past few years. However, the term proper
7 or common name is not new to the industry. It has always
8 been used by pharmaceutical manufacturers in this country.

9 It is interesting to note that the term
10 generic name does not appear anywhere in the Food and
11 Drug Regulations. The regulations for labelling state that
12 the proper name must appear on the label of a trade name
13 product in type not less than half the size of the type
14 used for the trade name, when the product contains a single
15 drug. However, when the trade name product contains two
16 or more drugs there can be no proper or generic name for
17 such a product. Only one or two exceptions exist.
18 Therefore, a large percentage of trade name products cannot
19 be identified by a proper name, common name or generic
20 name.

21 On the label of a trade name product con-
22 taining two or more drugs, the proper or generic name appears
23 only in the tabulation of the formula. Consequently, the
24 pressure to induce doctors to prescribe by generic name
25 or for consumers to demand generic name drugs in their
26 prescriptions is not practical.

27 The reference in the Food and Drug Regulations
28 to a "proper name" is where a monograph for the drug has
29 been published in one of the several compendiums, such as
30 the U.S.P., the B.P. or the National Formulary, etc. A



1 list of proper names for various drugs appears in section
2 C01.002 of the Food and Drug Regulations. The reference
3 to a common name means the name by which the drug is
4 commonly known and for which a monograph has not been
5 published.

6 Apart from the fact that trade names are a
7 basic fundamental of our free enterprise system, the
8 simplicity provided by trade names is sufficient in itself
9 to justify their use. A detailed study of 889 prescriptions
10 by Dean F. N. Hughes and Professor G. C. Walker of the
11 University of Toronto showed that 781 of these prescriptions
12 specified trade names. Of these 781, 376 or 42.3 per
13 cent were written for products containing more than one
14 medicinal ingredient, while 405 were written for products
15 containing a single medicinal agent. This illustrates our
16 point about the simplicity provided by the use of trade
17 names. Consider the position of the doctors in prescribing
18 these drugs under a non-trade name system:

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MR/dpw

1 Regarding the 405 single ingredient products,
2 the doctors would have been required to remember both the
3 generic names of the products, many of which are long and
4 complicated, and the names of the manufacturers.

5 Concerning the 376 products containing more
6 than one active ingredient, the doctors would have been
7 required to remember each of the ingredients, their
8 generic names, the quantity of each ingredient, and the
9 name of the manufacturer.

10 We suggest that this would place an intole-
11 rable burden on the prescribing doctor and dispensing
12 pharmacist. Furthermore, it is inconceivable that an
13 industry as important as pharmaceutical manufacturing
14 would be denied the right, which extends to every other
15 segment of industry, to use a trade name for its products.

16 The philosophy of insisting that all drugs
17 be prescribed by generic name does not mean that all such
18 prescriptions would be filled with non-trade name products.
19 Witness the statement before this Commission by Mr. Walter
20 Maday of the Alberta Pharmaceutical Association:

21 "Should it be the policy of physicians to
22 prescribe by generic terminology the retail pharmacists of
23 Alberta would not be unhappy. They would wish it known,
24 however, that they do not interpret this to mean that they
25 are required to supply the cheapest. It is a fairly well
26 recognized axiom that the cheapest is not necessarily the
27 most economical". It is doubtful whether the public of
28 Canada would stand for any measure which demanded that
29 the cheapest preparation be sold without regard for the
30 reputation of the maker.



1 The average Canadian can well afford the
2 price of today's pharmaceuticals, as has been shown, and
3 he will insist on receiving a product from a company in
4 which his physician has confidence. This product could be
5 either under generic name or trade name, but it is essen-
6 tial that the physician have absolute faith, based on his
7 own personal experience, in the integrity and ability of
8 the company to provide consistently good quality and
9 performance and this is not something which can be ensured
10 by legislation alone. Contrary to the green book's state-
11 ment in this respect, wholesalers do stock products under
12 generic name, and druggists can "obtain them quickly and
13 easily".

14 As we stated at the opening of this chapter,
15 many brand name companies also sell under generic name,
16 products which carry no trade name. A survey of 39
17 companies which we undertook in August past showed that 18
18 of these firms sell more than 400 products under generic
19 name alone. And these companies are considered prestige
20 firms by the medical profession. If we, as an Association,
21 bitterly attacked generic name suppliers then essentially
22 we would be attacking many of our member companies, which
23 is not likely.

24 Our sole stand here is that we are unalte-
25 rably opposed to any system which would prevent the doctor
26 from prescribing for his patients the products in which he
27 has the utmost confidence. If the trade name became
28 obsolete, price alone would become the criterion for
29 Canada's pharmaceutical manufacturing industry, and quality
30 and performance which are of prime significance, would be



1 lost. There would no longer be the guarantee of relia-
2 bility in the manufacturing of drugs which is demanded by
3 the doctor and is so important to the patient.

4 As Dr. Stewart stated, there is great oppo-
5 sition to the idea of equivalency of all drugs with the
6 same generic name. The reason for this is that all compe-
7 titive products of the same chemical composition are not
8 necessarily equivalents. This was borne out by the Hinch-
9 cliffe Committee on Cost of Prescribing in its report to
10 the U.K. Ministry of Health: "The term 'equivalent' may
11 be used in two different senses. It may imply identical
12 equivalent, where the identity is susceptible to proof by
13 chemical methods but even with products containing identi-
14 cal therapeutical substances there may be pharmaceutical
15 variations. The term 'equivalent' may also imply a thera-
16 peutic equivalent which can only properly be decided by
17 the prescriber".

18 Any experienced director of quality control
19 knows that chemical analysis alone is not sufficient to
20 tell whether one product is identical in every respect to
21 another. A product can meet chemical analysis for label
22 claim and conform with pharmacopoeia requirements, yet
23 still contain some variation produced in the manufacture
24 which could provide an effect on the patient not expected
25 by the physician.

26 In the case of the United States Pharmaco-
27 poeia, for example, the requirements are essentially
28 minimums, and the standards set by most pharmaceutical
29 manufacturers are generally higher in terms of efficiency.

30 Here are a few instances of this:



1. Regarding Tetracycline Capsules:

Studies of the absorption of tetracycline into the blood stream after administration of the capsules, showed that different formulations produced different concentrations of tetracycline in the blood. It has been found that if calcium compounds, like calcium diphosphate, are added as a filler during encapsulation of the tetracycline, it will bind some of the tetracycline and prevent it from being absorbed. This would result in much lower tetracycline blood concentrations.

It has also been found that citric acid will markedly improve the absorption of tetracycline and give much greater concentrations of this drug in the blood. Also, glucosamine may enhance the absorption of tetracycline. The USP does not specify that calcium should not be added to a capsule formula, nor does it specify that substances like citric acid and glucosamine would aid in the absorption of tetracycline. Accordingly, there could be differences in a product quite important to the patient, and yet they would be USP tetracycline capsules.

2. In the preparation of procaine penicillin G suspension, and sterile penicillin dihydrostreptomycin for suspension, each manufacturer has to make his own formulation to meet his definition of a satisfactory product. The USP permits the use of one or more suitable, harmless suspending or dispersing agents and preservatives, but does not state what these should be.

There are a number of such substances, such as carboxymethyl cellulose, polyvinylpyrrolidone, the tweens, lecithen, etc. Depending upon the manufacturer's



1 particular formula, some of these preparations remain
2 suspended for longer periods of time than others. Some
3 may be thicker or thinner suspensions. Others may produce
4 considerable foam when shaken. Still other companies
5 treat the surface of the glass with silicone to prevent
6 the preparations from adhering to the glass surface.

7 All of these may pass USP requirements, but
8 a physician may prefer one company's product over that of
9 another, because of its ease of suspension, viscosity and
10 other similar factors.

11 3. Regarding ointments, the USP states:
12 "In official ointments and suppositories the proportions
13 of the substances constituting the base may be varied to
14 maintain a suitable consistency under different climatic
15 conditions provided the proportion of active ingredients
16 is not varied".

17 It is recognized that variations in the
18 proportions of the ointment base could cause differences
19 in the absorption of active drugs through the skin. Also,
20 some manufacturers in preparing ointments micropulverize
21 the active drug ingredients so that they are extremely
22 smooth and non-gritty. This could be particularly impor-
23 tant in the case of ophthalmic ointments where lack of
24 irritation due to the medicament itself may be a factor
25 in why the doctor would prefer one product over another.

26 4. Sterile procaine penicillin G with
27 aluminum stearate suspension is made by suspending procaine
28 penicillin G in oil that has been gelled with two per cent
29 aluminum monostearate. There is a definite art in prepa-
30 ring this aluminum monostearate oil gel. If the gel is



1 not prepared properly, upon injection the concentrations
2 of penicillin remaining in the blood may be of a conside-
3 rably shorter duration than with a properly prepared gel.

4 Consequently, it was found that one company's
5 product gave penicillin blood concentrations, after the
6 injection of 1.0 ml. containing 300,000 units, for 96
7 hours. Other preparations tested varied in their prolon-
8 gation of penicillin blood concentrations from 24 to 72
9 hours. As the USP does not specify the manner in which the
10 gel should be prepared, there can be important differences
11 between two products although both would pass USP require-
12 ments.

13 A Medical practitioner learns by experience
14 the effect of a particular product on his patients. He
15 undoubtedly has prescribed over the years various products
16 of the same designation produced by several different
17 companies and, finally has settled on one which he prefers
18 for a variety of reasons. To deny that doctor this parti-
19 cular product would, in effect, be taking the responsibility
20 for the welfare of his patients out of his hands.

21 In an article in the Journal of the American
22 Medical Association, by Dr. Gerhard Levy of the University
23 of Buffalo and Dr. Eino Nelson of the University of Cali-
24 fornia Medical Center, it was stated:

25 "Formulation of drugs into various dosage
26 forms may modify profoundly the onset,
27 intensity, and duration of physiological
28 response, the correct dosage for the patient,
29 the incidence and intensity of side effects,
30 and the stability of the drugs. These



1 effects are illustrated by examples from
2 the clinical and scientific literature.
3 Because of the modifications discussed,
4 it is clear that in some cases choice of
5 dosage form and manufacturer's brand may
6 be as important as choice of the actual
7 therapeutic agent".

8 This is further borne out by an article in
9 the Canadian Medical Association Journal concerning
10 problems involved in the physiological availability of
11 the product, Dicumarol, by a research director of the
12 company concerned. In concluding his remarks, Dr. E.
13 Lozinski stated:

14 "Different brands of products, although
15 similarly labelled with respect to active
16 ingredient content, may not provide simi-
17 lar physiological responses. A brand
18 name has implications beyond commercialism".

19 Dr. C.C. Misener of the Department of
20 Veterans' Affairs testified before this Commission that,
21 "It is the policy to have newer drugs obtained from less
22 known companies assayed and tested by the Food and Drug
23 Division (sic)... Sometimes shipments have to be rejected
24 due to low quality..."

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1 These facilities are not available to the general
2 practitioner, who, regardless of the differences between
3 so-called equivalents, must rely on his own experience.
4 Furthermore, laboratory testing of the end product is not
5 an absolute guarantee of efficacy and safety. Such
6 testing must be preceded by exacting quality control pro-
7 cedures during the entire manufacturing process.

8 As you are aware, the Food and Drug
9 Directorate is presently establishing requirements for the
10 manufacture and importation of drugs, which will tend to
11 strengthen existing regulations. Notwithstanding comments
12 made to the contrary in Winnipeg, these proposed new
13 regulations originated in the Food and Drug Directorate,
14 and our Association as well as other interested groups have
15 been working closely with the Directorate on the countless
16 details involved.

17 In this connection, we undertook an ex-
18 tensive study of what might be done to strengthen manu-
19 facturing requirements in Canada. The results of this
20 study were then submitted to the Directorate. A considerable
21 amount of work has since been done by our Association in
22 this respect, and it is interesting to note that our com-
23 panies are unanimously in favour of strong and enforceable
24 regulations.

25 The reason for this is that most ethical
26 pharmaceutical manufacturers now maintain strict control in
27 their manufacturing operations to ensure the efficacy and
28 safety of products and their consistency from batch to
29 batch. This is a form of self-regulation, and there is
30 presently no law requiring such control for pharmaceutical



1 preparations. There can be no doubt that this is in the
2 best public interest, and we believe that ever product
3 imported or made in Canada should be produced in conformity
4 with sound manufacturing principles and under proper
5 quality control procedures. Obviously, it would be most
6 difficult for any government body to guarantee every batch
7 of products sold. But the proposed regulations are a move
8 in this direction, and we believe that the government should
9 be congratulated in taking this forward step.

10 Some lay authorities in this country
11 apparently are under the mistaken impression that these
12 forthcoming regulations will in essence place the
13 government's stamp of approval on every product sold in
14 Canada. As has been mentioned many times, it is virtually
15 impossible for the government to verify chemical analysis,
16 efficacy, potency and the countless other factors involved,
17 of every batch of drugs marketed in this country. Not
18 only is it impractical from an economic standpoint, but
19 quality control is not something which can be determined
20 from analysis alone. It must be built into the product
21 during the manufacture.

22 The green book comments on the "alleged
23 superiority of drugs sold under brand names over drugs
24 sold under generic names." The superiority of the brand
25 name system is not an allegation but a fact, based as it
26 is on the integrity of the maker. This naturally does not
27 mean that every person who places a trade name on a pro-
28 duct provides equal quality, reputation and performance,
29 any more than a government purchase ensures the quality
30 of all generic products sold at retail.



1 But it stands to reason that a company
2 which is prepared to place a name on its product, and
3 establish a reputation for consistent quality with the
4 medical profession, is going to do its utmost to ensure
5 that the high quality of the product is maintained and
6 is consistent from batch to batch during its lifetime.
7 No large company could retain its share of the market
8 without this product consistency, for it has invariably
9 attained its position by proving to doctors over the years
10 that it has a sound reputation for uniformity. Promotion
11 by itself will never sell a doctor on products in which
12 that doctor has found inconsistencies over the years.

13 To be completely successful in this industry,
14 a company must first earn the confidence of the medical
15 profession. And there is no short-cut to gaining this
16 confidence.

17 The green book draws a line between large
18 and small manufacturers and in at least one place infers
19 that there is a comparison between a "small" firm and a
20 so-called "fringe" firm. If the intent is in its
21 derogatory sense, then it is incorrect. Many small firms
22 are reputable and highly respected companies. In another
23 reference to a controversy between Parke Davis and Intra
24 Medical, the green book creates the impression that this
25 was in the brand v. generic area, tied in as it is to that
26 subject in the green book. This probably was not the
27 author's intention, but it would create that impression to
28 an inexperienced person.

29 Both Parke Davis and Intra Medical sell under
30 trade name and, if anything, this controversy indicates



1 clearly that there is strong competition in this industry.

2 We do not propose to go into the complexi-
3 ties of quality control in this submission, but if the
4 Commission so desires, we are prepared to answer any
5 questions concerning quality control which you may have.

6 THE CHAIRMAN: Mr. Conder, I think perhaps
7 we might stop for the day. I don't want you to get
8 laryngitis. We will adjourn until ten o'clock tomorrow
9 morning.

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12 ---Whereupon the hearing adjourned until 10 a.m.,

13 Thursday, October 19th, 1961.

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